A PHENOMENOLOGICAL EXPLORATION OF THE RELATIONSHIP EXPERIENCES OF HEALTH PROFESSION STUDENTS IN A CONTEXT OF INTERPROFESSIONAL CLINICAL PRACTICE

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By

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ABSTRACT

Interprofessional collaboration in health care practice is thought to be an answer to the issues of costs and quality of care in health care services (Chong, Aslanie, & Chin, 2013, Meads & Ashcroft, 2005, World Health Organization 2010). Salfi, Allen, Mohaupt, & Patterson, and (2012) stated that it would be preferable for health care professionals to enter practice with the skills for interprofessional collaboration (IPC) in place. While some studies have explored the experiences of students with IPC, more in-depth understanding of their experience continues to be needed.

Practitioners and students of the health care professions interested in interprofessional collaboration extended the hours of a primary care clinic in a low-income area of a western Canadian city to provide services for its citizens. An interpretive phenomenological study was carried out involving students who were volunteers in the clinical project. Major findings related to a social justice orientation facilitated by the Social Determinants of Health model, the perceived need among the participants for more clinical practice experience and learning from each other, their mentors and the people who used the clinic, and about themselves as well as clinical practice in a low-income neighbourhood. Their most profound learning was provoked by situations that produced dissonance which caused them to reflect more deeply on the issues.

The participants in the study found the experience of volunteering at the clinic to be “addicting”. The philosophy directing the program was embraced by each of them. They loved working with the community members, the patient centred, holistic approach, and knowing that there were other experienced practitioners there who would carry on when they were not there.

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CHAPTER I: INTRODUCTION AND PURPOSE

Recently there has been a heightened interest in collaborative interprofessional practice in health care, based on the belief that collaboration among professionals would increase the quality of health care while decreasing its costs (King & Ross, 2003; Meads & Ashcroft, 2005; Paradis & Reeves, 2013). There is also a common belief that one of the most important methods of ensuring collaboration in practice is to teach students of the health professions to collaborate in working relationships throughout their training programs (Makino et al., 2013). Given the historical development of health care profession relationships there are questions about how best to proceed with guiding the relationships among students, and how these relationships affect their learning and practice. The focus of this research is the experience of the nature and the process of making meaning of collaborative relationships by students in an interprofessional setting. While this research focused on students practicing as volunteers in an interprofessional collaborative practice the participants in the study were also learning about health care practice, in their own chosen profession and those of other health care professions through collaborative assessments, decision making, and care.

Incentive for Interprofessional Education and Collaboration

The *Primary Health Care Model*, developed by the World Health Organization (WHO) at Alma Ata, Kazakhstan, in 1978, provided an introduction to the benefits of interprofessional collaboration and set the stage internationally for the adoption of this approach (World Health Organization, 2003). Two of the principles guiding this model are key to interprofessional collaboration for patient-centred care. Interprofessional collaboration relates to the WHO

principle of intersectoral collaboration. WHO did not limit health care to the health care system when it defined health as being affected and determined by many sectors in society such as education. The other principle of interest is public participation. Again, this principle was broader in scope than patient-centred care. The principle states that people who are likely to receive health care should be involved in the planning and implementation of the system. It is also noteworthy that the authors of the 2003 revision of the original Declaration of Alma Ata (WHO, 1978) called for education related to working in primary health care in ways which were appropriate for their contexts. The WHO explained in the 2003 document that there are diverse professions involved in the health of the people and that they must be educated to work together toward the goal of health for all which would include interprofessional teams.

The Centre for Interprofessional Education (CAIPE) defined Interprofessional Education (IPE) as educational experiences that occur when two or more professions learn with, from and about each other to improve collaboration and the quality of care (2002). In order for this learning to occur students must understand and value each other's scope of practice, knowledge, and skills.

The importance of interprofessional relationships for the quality of health care came to the fore in the acute care sector due to the widely publicized deaths of infants and children in Bristol, England (Meads & Ashcroft, 2005) and Winnipeg, Canada (Ceci, 2004a, 2004b). In both countries, a number of babies were found to have died or suffered increased incidences of complications due to the incompetence of cardiac surgeons performing in a particular surgical procedure. Although other health professionals were aware of the increased morbidity and mortality rates, and communicated these concerns to appropriate people in the hospital hierarchies, the significance of these reported concerns was denied by the surgeons and

administrators of the respective hospitals.

In the Bristol Royal Infirmary case in England, the warning was repeatedly given by an anesthetist who was given the responsibility to investigate the problem further and supply statistics to support his complaint. This was an ineffective strategy to deal with the problem, and resulted in the deaths of more infants. It was not until the anesthetists took collective action by refusing to work with the surgeon that the issues were regarded as significant (Meads & Ashcroft, 2005).

In an additional English case the death of a young girl in England added the influence of poor interagency communication and follow-up to the concern about interprofessional relationships (Meads & Ashcroft, 2005). This child was under the guardianship of her aunt who was abusing her. On multiple occasions the child was taken to various agencies for treatment or assistance but communication was poor and follow-up was neglected, resulting in her death from the mistreatment.

These notorious cases provoked government policy change for interprofessional collaboration and a strong push toward interprofessional education (Meads & Ashcroft, 2005). The prominence of British projects and studies in the early interprofessional education and collaboration literature was not coincidental, given the strong governmental stance for the promotion of interprofessional collaboration.

In a Canadian case, it was the nurses who reported their concerns. They noticed that there were more complications and deaths with a certain procedure coincident with the arrival of a new surgeon to Sick Children's Hospital in Winnipeg; however, their conclusions were denied and their concerns ignored by the head of the surgery department (Ceci, 2004a, 2004b). Ceci (2004b) concluded that the issue was one of gender and subordination of nursing knowledge.

Once the issue became public, swift action was taken and the cardiac surgery unit of the hospital was shut down for an extended period. Officially the move toward interprofessional collaboration and education in Canada has come not as a direct outcome of this case but rather has been based on economics and adequate staffing issues. These concerns developed into a national plan for health human resources (Oandasan et al. 2005).

Nurses' knowledge has at times been considered subordinate to that of physicians, stemming, perhaps, from the gender issue or from historical societal structures Ceci, 2004b). Women were not admitted to universities when medicine was enhancing its status by moving its education programs into the universities, a situation that disadvantaged the credibility of nursing knowledge (Baly, 1998).

Nursing was considered to be an occupation innate to the nurturing role of women, as exemplified by Nightingale's *Notes on Nursing* (Nightingale, 1859/1946) that were aimed at the women of the house, rather than at professionally educated women. Nightingale stipulated that nursing was a separate function from medicine and she endeavoured to have her nurses trained for that distinct role. However, she found herself having to hire a physician to teach the medical basis for her students (Baly, 1998). This practice served to perpetuate the belief (having some relevance for IPC effectiveness) that nurses are doctors' helpers and under their authority.

Health care is not provided exclusively by doctors and nurses. There are other health professionals who contribute to care, under the descriptive grouping of 'allied health professionals'. Examples of these professions are physiotherapists, speech language pathologists, and medical laboratory technicians. Gilbert (2005b) stated that this congregate description reduced the significance of the contributions provided by the members provided by each of the professions. Gilbert believed that hierarchy and subordination among health professionals were

barriers to collaborative relationships.

The earlier described tragedies gave emphasis to the importance of interprofessional relationships in safe health care practice. Health Canada expanded this idea in its statement that quality of health care that has resulted from collaborative practice will not only save lives but it is fiscally responsible (Engel & Prentice, 2013; Health Council of Canada, 2005; Legare et al. 2013). There is a modest amount of research to support this belief (Barrett, Greenwood, & Ross, 2003; Zwarenstein et al., 2005a). However, Zwarenstein, Bryant, and Reeves (2003) did find that a collaborative approach to health care provision served to increase the quality of care and to decrease costs compared to traditional approaches. In 2012 the Health Council of Canada reported there was some development of collaboration in Canada and that the supply of human resources was improving.

While many authors have addressed the need to have health professionals prepared for collaboration through interprofessional experiences before they graduate, there is little research related to how these collaborative relationships are formed (Reeves & Lewin, 2004). Because the relationships were seen as a critical piece, whether it was to increase quality or decrease cost, this lack of understanding is surprising. In their review of pre- and post-licensure studies Zwarenstein, Reeves, and Perrier (2005b) described the issues with assessing pre-licensure education interventions, one of which was the need for long-term studies which follow the participants into professional practice. These authors, like the majority of researchers in the area of IPE/IPC, focused on the need for quantitative evidence that collaborative working relationships are effective. In 2013 Duner stated that quantitative studies focused largely on the results of teamwork mainly from the perspectives of efficiency, patient care, and team atmosphere. To fully understand the dynamics of IPE/IPC relationships in pre-licensure

experiences would require carrying the research through the pre-licensure phase in order to understand the development of collaborative relationships in health care. In addition, the study of IPE/IPC should continue into the post-licensure period to understand the influence of the pre-licensure experiences on relationships in the workplace.

Theories Underlying Interprofessional Education and Research

In addition to the lack of research there is a lack of theoretical underpinnings upon which to base an education plan for the development of these relationships, (Cooper, Carlisle, Gibbs & Watkins, 2001; Jaye, Egan & Parker, 2006; Scott & Thurston, 2004) and the interprofessional curricula (Clark, 2007; Horsburgh, Perkins, Coyle & Degeling, 2006; Massey, 2001), although more recently this is improving (Paradis & Reeves, 2013). The importance of having a specific framework to guide education is that it can provide direction to the curriculum development process (Oliva, 2006) and can assist with identifying and clarifying what the students need to learn (Posner & Rudnitsky, 2006). The findings of research based on theory also provide direction for facilitation of student and faculty learning. Clark (2007) specified that theory for interprofessional education and collaboration must answer the following questions:

- What concepts should be used in the planning of programs and courses?
- What should the learning objectives and strategies be? What are appropriate roles for students and faculty in interprofessional education?
- What is the basis for evaluating program effectiveness?

Paradis and Reeves in their recent review of the literature (2013) found that, increasingly, IP research and educational projects were being based in theory and Barr (2013) suggested several theories that would be useful for research into interprofessional collaboration. For example, adult learning theories included concepts such as reflective and socially constructive learning, experiential learning (Kolb, 1984, Mezirow, 1981, & Schön, 1983, 1987), communities

of practice (Wenger, 1998) and Senge's work on the learning organization. Systems theories are useful for understanding the workplace in order to work toward improvement in service; these theories assist in understanding and directing the dynamics in and between groups such as those of students of various health professions when learning and practicing together. Contact theory has been found in the IPE/IPC literature (Barr, 2013). Wenger's work on communities of practice is related to contact theory in that employees engaged with other types of workers in the organization in order to carry out their daily work. At times they negotiated their roles and the use of shared resources (1998). Barr also identified Social Identity theories to develop and support research in IPE/IPC. These theories promote the understanding that people prefer a positive identity, for example, belonging to an 'Ingroup' with resources attributed by others' opinions of their status (Hean, Clark, Adams, & Humphris, 2006).

Another theory that applies to IPE/IPC is that of the professions, the classic version being that of Friedson (1970) who determined that certain qualities, such as lengthy education, altruistic intent, and autonomy, were critical in order for a group of workers to be considered professionals. This can be viewed as perpetuating the historical hierarchy among health care professions based on prestige and monetary reward. The hierarchy may be seen as an entrenchment of the relative status of each health profession in relation to the medical profession in that the status and monetary remuneration are higher than that of several other health professions. The importance of revisiting Friedson's work is to reflect on its influence on current social identity and status among the various health care professional groups and professional relations in health care. In acute health care organizations work is often urgent and complex given the advances in ability to control or cure diseases and disorders that could not previously be done in the is lifetime of these theorists. The highly technical and stressful environment and

work can be chaotic. Barr (2013) stated that chaos and complexity theory is useful to understand the process and to give reassurance that situations will settle into a new pattern and achieve equilibrium. The complexity of health care knowledge and practice needed by students of the health care professions requires an interdisciplinary knowledge and research base. Paradis and Reeves (2013) focused on the research related to IPC practice and found that more of the research was developed on theoretical foundations and that the term 'team' was often replaced by the term 'collaboration'.

Literature Reviews of Interprofessional Research Based on Theoretical Models

In order to determine the underlying perspectives guiding interprofessional projects, D'Amour, Ferrada-Videla, San Martin Rodriquez, & Beaulieu (2005) conducted a review of the research literature in which theoretical frameworks or concepts were used to guide the study of interprofessional collaborative relationships. These authors classified the theoretical concepts on the basis of whether they applied to *collaboration* or to *teams*. They found that the most common concepts related to *collaboration* in these studies were sharing, partnership, interdependency, power, and collaboration as a dynamic process. Within the research literature related to *teams* they found that there was a continuum of professional autonomy, conveyed by the use of the terms multidisciplinary, interdisciplinary, and transdisciplinary.

At the multidisciplinary end of the continuum the professional autonomy is high, whereas at the position of transdisciplinarity, professional autonomy is lower but team autonomy is high.

D'Amour et al. (2005) found that the frameworks used in research related to teams were either from organizational theory which focused on team efficiency or on organizational sociology which focused more on the dynamics of relationships in the organization. Overall they found a lack of consideration for the patient perspective in the studies and their frameworks.

Health Canada saw interprofessional education as the way to achieve quality of care through interprofessional collaboration. Most of the education research focused on varying degrees of student collaboration in interprofessional learning projects (Oanadasan & Reeves, 2005; WHO, 2003). Other researchers have used psychological theories such as engagement and connection to study motivation, job satisfaction, and commitment to work, especially for volunteers (Huynh, Metzer & Winefield, 2012; Schaufeli, Saranova, & González-Romá (2002). These studies provided findings to inform organizations about approaches that can improve or maintain the participation and retention of their volunteers.

Zwarenstein, et al. (2005b) reviewed studies of effectiveness of pre-licensure interprofessional education and post-licensure collaboration. They found no evidence that pre-licensure interprofessional education had an effect on patient outcomes but that improvement in outcomes was shown in the post-licensure research. This finding together with the lack of models for interprofessional education, led them to caution against proceeding with the pre-licensure interventions before models were developed, tested, and found to be effective. More recently, Makino, et al. (2013) noted that more evidence shows that pre-licensure IPC experiences improved the skills for collaboration in future practice.

Concepts, Models, and Frameworks for Interprofessional Education

Several authors looked at possible concepts, models, or frameworks to guide the development of interprofessional education, collaboration, or both. Most of the theory based literature was related to discussion of the fit of specific concepts or theories with interprofessional education or collaboration. Clouder (2005) explored how the experience of caring could be used to have students explore fundamental beliefs and values. Clouder focused on values in general as an effective way to educate interprofessionally, noting that “effective

interprofessional collaboration depends upon establishing understanding that respects differences in values and beliefs and thus differences in response to the multiplicity of patient/client/user needs" (1999, p. 202).

Contact theory has been a common theme in studies on interprofessional education. Hean and Dickinson (2005) and Oandasan and Reeves (2005) explored the use of contact hypothesis as a basis for interprofessional education. According to Hean and Dickinson and Weinberg, Cooney-Miner, Perloff, Babbington, and Avgar (2011) the increased contact that nurses have with other professionals predisposes them to collaboration. Hean and Dickinson stated that in order for contact among students and student professional groups to be effective in developing interprofessional attitudes and values a safe environment must be provided.

Leaviss (2000) suggested that the requirements for the health care environment consisted of equal status in the group, cooperative atmosphere, common goals, institutional support, awareness of similarities and differences, and expectations that they see each other as being typical of the professional group that each represents. In interprofessional education, contact between the students would give opportunities to learn about each other, form friendships, and reappraise their own and other's professional identities. Barr (2013) noted that Contact theory would be useful for IPC initiatives. Contact theory is premised on the belief that if contact with other health professionals is infrequent it is difficult for collaborative work relationships to develop. Oandasan and Reeves (2005) added the stipulation that students must feel safe to express themselves in the group of health professional students.

Finally, in the area of interprofessional education, D'Amour and Oandasan (2005) developed the concept of 'interprofessionality' to guide interprofessional education:

> Interprofessionality is defined as the development of a cohesive practice among professionals from different disciplines. It is the process by which professionals

> reflect on and develop ways of practicing that provide an integrated and cohesive answer to the needs of the client/family population (p. 9).

They differentiated interprofessionality from interdisciplinarity by noting that interdisciplinarity is "a response to the fragmented knowledge of numerous disciplines" (p. 9). Interdisciplinarity was seen to be research focused whereas interprofessionality was described as practice based. They also stated that it was important to distinguish between interprofessional collaboration and interprofessional education. D'Amour and Oandasan's model had two main components: one had the learner's needs at the core and included all the teaching, institutional, and systemic factors that affected the students' abilities to become effective in collaborative practice; the second centred on the patient and was comprised of the interrelational (*micro level),* organizational (*meso level)* and systemic (*macro level)* factors that affected patient outcomes. Using this framework one could study both the learner's educational needs and experience to become collaborative practitioners and the factors related to the practitioners' efforts to provide effective, patient-centred care. These components of interprofessional education and collaborative practice included interactions among the micro (teaching), meso (institutional), and macro (system) levels of their respective environments and foci.

Massey (2001) described the revision of a transdisciplinary curriculum. The transdisciplinary components of the curriculum were focused on roles and processes in health care. She cited the needs for the attention in health care to be focused on the patient or client rather than provider, and for consideration to be paid to the whole person as the reason for choosing a transdisciplinary approach as opposed to an interdisciplinary one. Massey stated that the interdisciplinary team structure did not provide for full collaboration in practice. The concept of Patient Centred Care was reinforced as an important factor or motivator for IPC by DeMatteo & Reeves (2013) who found in their review of the literature that "efficiency and patient centered

care were the two most frequently identified (and often linked) reasons students gave for incorporating interprofessionalism into their education and practice" (p. 31).

From this discussion the scholar could conclude that there is more to IPE and IPC than any one of the theories available at this time. Each of the above theories would contribute important direction for IPE and IPC however there would be gaps in the approaches if only one were selected. The answer may be combining selected portions and intents of known theories to guide IPE and IPC or starting over with complete theories specific for IPE and IPC informed by current theories and research. It seems appropriate that IPC theory should be based on interdisciplinary knowledge and theory from a mixture of disciplines.

Theories Influencing the Researcher

In qualitative research it is not necessary to begin with a theoretical framework, other than that which guides the choice of methodology. In this case, because I am an educator in a health profession discipline, and a student in Educational Administration, it was especially important to declare the theories that guided my reasoning in the area of relationships in interprofessional education and in my decisions in this research. These theories related to professional socialization, social identity and constructivism.

Professional socialization has been thought to be an issue in interprofessional education, from the perspective of deciding when to introduce interprofessional learning and in respect to relationship development (Freeth & Chaput de Saintonge, 2000; Hale, 2003; Harden, 1998; Wood, 1999). Closely related to professional socialization are theories of social identity. Social identity as a particular health professional, may be seen as the outcome of professional socialization. Social identities are constructed through relationships with faculty, practitioners, other students, and patients, through learning activities provided by their educational programs.

The process of social development of identities and relationship formation is clearly seen through a constructivist lens as well. Clark (2007) effectively showed the relationship among these concepts:

> The basic cognitive structures of a discipline are ultimately the construction of communities of faculty, students, and peers who share the same worldview. The process of becoming a professional, of being socialized into the patterns of thinking and behaving that the professional requires, is ultimately a social one in which facts, realities, types of knowledge, patterns of thought, and ultimately, self-identities are constructed from a shared sense of reality assumed by that group. (p.580).

A discussion of the concepts of professional socialization and social identity follows.

Professional socialization and its impacts.

One of the aims of professional education is to instill values, principles, and ways of thinking, working, and presenting the self in the new recruits (Costello, 2000; Jaye et al., 2006). It was found that students enter education programs with stereotypes in place (Hean, Clark, Adams, & Humphris, 2006; Tunstall-Pedoe, Rink, & Hilton, 2003) and that differences in approaches to work were apparent among students in the professional programs (Horsburgh et al., 2006). For example, students entering medicine were found to have an individualistic approach whereas beginning nursing students thought that working in teams was preferable. The predispositions of the entering students, in combination with faculty and clinicians who have been socialized into traditional hierarchical relationships, provided a huge challenge for those who were leading the change within the institution towards greater interprofessional collaboration (Jaye et al.; Horsburgh et al.).

The most common product of professional socialization discussed in the literature was that of the differential in power between doctors and other health care professionals, most notably nurses (Daiski, 2004; Hall, 2005; Rice, Conn, Zwarenstien, Kenaszchuk, Russell &

Reeves, 2010;). This differential stemmed from the Victorian age when men who were in medical-related practice joined together to raise the practice of medicine in status and quality through licensure (Baly, 1998). As other health professions developed they consisted mainly of women who had shorter and less academic preparation for the chosen field. Because of the effects of the gender differentiation and the societal structure at this time, health care was, and continues to be, hierarchical (Baly; Kilminster et al.,2004; Rice et al. 2010). Now the previously established hierarchy is preserved through perpetuated gender-based influences on relationships (Davies, 2003; Rice et al. 2010), continued educational differences, preferential treatment of positivist knowledge, and large hierarchical health care organizations (Manias, & Street, 2001; McCallin, 2001).

Social identity.

While professional socialization in the education process is seen as an important aspect related to effective collaboration, little is known about the way it affects student relationship formation in interprofessional settings. Hean, Clark, Adams, Humphris & Lathlean set out to "extend what little is known of the processes that govern intergroup relations in and when working in an IPE context, to determine the potential influence of these on student learning" (2006, p. 11). They used social identity theory to guide their research and found that there were discrepancies in the ways that various groups saw themselves and each other. They also found that the students they studied had identities formed for their future professions even as they started their programs. This finding was consistent with the research related to stereotyping in health professions students.

The skills, roles, attitudes, and values, the attributes passed on in the socialization process, are a large part of one's professional identity. Professional identity could be said to be a

socially derived identity:

> Social identity theory is based upon the idea that individuals may derive their definition of self from their group memberships. Social identity is the identification of self in terms of one's own social group (in-group) rather than of another group (outgroup) (Hean, et al., 2006b, p. 11).

One could say then, that the construction of the professional social identity is one significant objective of professional socialization.

Reynolds, Turner, & Haslam (2000) took the concept of social identity a step further, specifying that people wanted a positive identity; therefore they established a positive distinctiveness for their own group in relation to the characteristics of other groups. Commitment to one's own group depended on whether the members internalized membership as part of their individual social identities. Other factors in the development of the social identity in relation to other groups were the *relevance* of the out-group as a comparison group, and the perceived *importance* of the dimension being compared. If neither the relevance of the group nor the importance of the characteristic were high, then neither the out-group nor the dimension was significant in the development of social identity. The need for a positive identity was not necessarily related to seeing negative characteristics of the significant outgroup. Reynolds et al. found that attributing negative aspects to a group were seen as less moral and ethical than increasing the positive value of the in-group characteristics. The exception to this finding was that when group status was insecure, both negative and positive discrimination with respect to outgroups could occur.

One could easily see the importance of distinctive characteristics for each group in the formation of professional identity. These characteristics defined the scope of practice and the approach to the work of each profession in terms of attitude, skills, and values and enabled all

groups to work together effectively in the provision of health care. However, Hean, Clark, Adams, Humphris, and Lathlean (2006) worried that differences in characteristics attributed to a group by others might lead either to intergroup conflict or expectations that were too high for group members. Other authors wrote of the fear that interprofessional education would blur the distinctions between the groups and lessen professional identity (Pirrie, Wilson, Harden, & Elsegood, 1998).

The value of constructivist theories.

According to Thomas, Menon, Boruff, Rodriguez, & Ahmed (2014), constructivist theory is a sociological theory of knowledge that focuses on how individuals construct and apply knowledge in socially mediated contexts. They believed that the social nature of learning: (CAIPE, 2002) was valuable for students of the health professions in interprofessional learning activities which required learning in social environments. One of the desirable characteristics of interprofessional collaboration is that of democratic decision making (San Martin Rodríguez, Beaulieu, D'Amour, & Ferrada-Videla, 2005, Weinberg, et al., 2011). The traditional power hierarchy perpetuated by professional socialization was seen as a hurdle for effective collaborative relationships (Rice et al., 2010). The individualist approach to work exhibited by the beginning medical students in Horsburgh et al.'s study (2006) also impaired collaboration. Much has also been said about the care versus cure orientations of various health professions (Bauman, Deber, Silverman & Mallette, 1998; Keeling, 1996). This hierarchical aspect of health professions has been connected to value systems that may or may not be self-selecting factors guiding application to professional programs.

Constructivist theories can also provide insights into the development of interprofessional relationships by students, particularly in relation to decision making, the predominant

collaborative task of the interprofessional group. Part of the differential among the various health professions resulting from professional socialization is related to the traditional hierarchical organization of work, and the accompanying discrepancies in power (Jaye et al. 2006). The way things are done and the common patterns of interaction within groups create and then perpetuate these patterns often imbuing them with value. “Power is continually constructed, negotiated, and exercised through interactions and relationships between individuals and groups who come into contact with each other in medical settings” (Jaye et al. 2006, p. 142). Jaye et al. studied professional socialization, or the “rules about how doctors should behave, think and feel” (p. 11) that were transferred by the educational and practice institutions in which students of the health professions learned. They also noted that power was continuously constructed through the interactions and relationships of the different groups involved in providing health care.

According to Black & McClintock (1996), in a constructivist environment, students “collaborate in observation, interpretation, and contextualization” (p. 26) of their learning. This is one means of addressing the concerns identified by Jaye et al. (2006) pertaining to the traditional hierarchical organization of work. In the learning environment set to prepare students of the health professions to learn to collaborate interprofessionally, the constructive actions also included negotiation of their identities as members of the health care team (Wenger, 1998). Through the faculty and practitioners’ attempts to socialize their students into their professions, students were influenced by the role modeling of attitudes, hierarchy of knowledge according to significance of the professional practice, status, and relationships with other health professions. The influence of the faculty and practitioners was apparent in the way students negotiated for their identities and roles in the relationships, as well as the credence that their knowledge and interpretation received in the full interprofessional group. This study demonstrated that students

of a health profession could be socialized for their own chosen professions in spite of working with students of other health professions to solve clinical problems.

An interprofessional learning environment can be an ideal context for constructivist learning because the diversity of health professions involved are seen to bring multiple perspectives which would increase student understanding and flexibility (Black & McClintock, 1996). The interaction of these multiple perspectives increased students' abilities to transfer learning to different situations. If faculty or practitioners involved with the students showed that they valued these traits, student collaborative learning was supported. Sommerfeldt, Barton, Stayko, Patterson,& Pimlot, (2011) saw constructivism as a foundational theory for IPC in order to avoid the continuation of silos of professions. It was apparent that the role of the faculty and practitioners was influential in students' construction of their relationships with each other. Faculty and practitioners played a significant role in professional socialization of students, including role modeling relationships with other professionals. It was also shown that there might be an element of self-selection of students into the health profession educational programs, based on the professional identity that they want, as found by Horsburgh et al. (2006) and Tunstall Pedoe et al. (2003). Students continued to develop their identities in relation to their chosen profession through relationships with students in their own profession and in other professions during their educational programs. These identities were also constructed through their interactions with others, such as practitioners, patients, and other members of society.

While these theories of professional socialization, social identity, constructivism, and communities of practice, shed some light on how students form their relationships and what the influences on this process are, there is a need for research exploring the process that underlies the success of interprofessional collaboration such how to break down the hierarchy, stereotypes,

and silos of learning and practice that still exist and are an impediment to full IPE and IPC. (Rice et al., 2010). There has been little research based in theory for IPE and IPC until recently (Barr, 2013; Paradis & Reeves, 2013), nor is there a theory specifically for IPE or IPC.

Purpose of Research

The purpose of this research was to gain understanding of the relationship experiences of health profession students in a context of interprofessional clinical practice. The questions that guided the study were:

1. What are the students' experiences in forming and working in interprofessional relationships?
2. What sense do the students make of these experiences and relationships?

To address these questions a hermeneutical phenomenological approach was used to uncover the experiences and the significance of those experiences to the students. For the purposes of this study the professions involved were those represented by the students of the health care professions working in a student run primary care practice called Student Wellness Initiative toward Community Health (SWITCH).

Definitions

Within the literature on interprofessional education and collaboration there continues to be a confusing array of terms and definitions relating to people learning and working together. Paradis and Reeves (2013) found that the terminology being used is evolving. While the term 'interprofessional collaboration' is used more frequently there continues to be confusion in labelling the ways of working together (Paradis & Reeves). Often terms such as *discipline* and *profession*, and prefixes such as *multi* and *inter* are used interchangeably. *Interprofessional education* and *interprofessional collaboration* are related in that the former prepares professionals for the latter. This was a study of student experiences and sense making. Given this

direction the major terms that follow were points of departure and are not intended to guide student interpretation of their work. This is a clarification of how the terms are used in the broader community.

Discipline.

A discipline is the study and knowledge generation in a specific area of interest. In education it is the subject matter taught (Oandasan & Reeves, 2005). People who teach or research in a specific discipline may be referred to as members of the discipline.

Profession.

A profession is the group of people who apply a specific body of knowledge in practice. Preparation for the profession often involves a lengthy education program (Oandasan & Reeves, 2005). The profession may be informed by more than one discipline but its particular knowledge comes from the study of application of these concepts and theories in the professional practice. For example, the health care professions may routinely apply knowledge from the disciplines of anatomy, physiology, genetics, biochemistry, microbiology, nutrition, sociology, psychology.

Multidisciplinary.

A multidisciplinary approach involves people from more than one discipline working in parallel to enhance a body of knowledge by studying or doing research informed by the knowledge of each of their disciplines (Oandasan & Reeves, 2005). This work is accomplished by representatives of each discipline contributing the portion of this work related to their own discipline. In this case each discipline may work in relative isolation from the others for its contribution.

Interdisciplinary.

Interdisciplinary work is distinguished from Interprofessional work in that its intention is to increase knowledge in a particular area whereas Interprofessional work is about effective working in practice. In interdisciplinary work, more than one discipline collaborates on a project through joint decision making and mechanisms to keep the whole group currently informed of progress made. There may be more than one discipline collaborating in several of the sections of the work. For example, a group of researchers may be undertaking a research project related to the experience of health care for rural women. The group members collaborate in writing the proposal. Expertise of each discipline is recognized through accepting the leadership of the appropriate discipline in the sections that relate to that discipline's area of knowledge (Oandasan & Reeves, 2005).

Multiprofessional.

Multiprofessional practice involves representatives of two or more professions that are engaged in the same project but working in parallel to each other (Engel & Prentice, 2013). For example, when a patient in a health care facility requires rehabilitation treatment by both a physiotherapist and an occupational therapist the patient goes to the physiotherapy department at one time and the occupational therapy department at another. The whole health care team meets to discuss the patient's progress at regular intervals however the treatment decisions are usually made by the staff member whose profession encompasses the practice required.

Interprofessional.

Representatives of two or more professions are engaged in achieving a common goal through sharing tools, knowledge, and decision making (Gilbert, 2005b). Each professional respects the expertise of the others to the extent that he or she follows the lead of the most

relevant expert for the stage of the work. Continuing with the example above, in an interprofessional team the nurse, physiotherapist and occupational therapist may work together in the patient's room, each adding his or her expertise in the collaborative sphere of decision making for the patient's morning care.

Interprofessional education.

Interprofessional education refers to teaching and learning activities in which teachers and students from different professions are actively engaged and interacting with, from, and about others to achieve a common goal (CAIPE, 2002).

Interprofessional collaboration.

Interprofessional collaboration is the democratic working together of two or more professions toward a shared goal. In the health professions:

> The two constant and key elements of collaboration are: (1) the construction of a collective action that addresses the complexity of client needs, and (2) the construction of a team life that integrates the perspectives of each professional and in which team members respect and trust each other. The two purposes appear to be inseparable, inasmuch as one cannot collaborate without having taken the time to develop a collective life, and there is no use in developing a collective life without having first established the need to collaborate in responding to identifiable patient needs (D'Amour et al., 2005).

Collaborative working together does not mean voting on decisions, rather that when decisions are made respect is paid to the input of all the members of the group.

Positionality

Due to the methodology that was used in this research it is important that future readers have a picture of what brought me to an interest in interprofessional work, and the values and theories that under laid my thoughts about student relationships in

interprofessional activities, so that potential or actual biases in this research may be identified and addressed. During my past years as a graduate student I have read a large part of the current literature on interprofessional education, particularly in the health sciences area, as shown in the second chapter. My past experience not only set me up to embrace the purpose of interprofessional education, but also coloured my thinking about it.

I grew up in northern Alberta toward the end of the development stage of agricultural communities in that area. In order to survive the pioneers had to both work and play together. I had a truly idyllic childhood as a member of close and collaborative communities. I started school in a four room school in which at least two different grades were taught in each room. My parents refused to allow me to 'skip' a grade because they thought my social relationships with my own age group were more important. Social relationships were considered important due to the relative isolation of the northern communities and the need to help each other at that time.

My first degree was sociology because I had internalized the social justice ethic of my parents and wanted to help others through social work. I changed once I realized that I would really rather do that through nursing. Shortly after graduating from nursing I started working on a Physical Medicine and Rehabilitation unit in a teaching hospital. This department prided itself on its 'multidisciplinary' team approach, which at that time was still heavily based in the medical model, and where the doctors firmly held the leadership roles on the team.

Three years later I became the head nurse of this unit and my multidisciplinary contacts and activities broadened beyond the patient unit. I loved the diversity and network of relationships that developed in my job. Eventually I changed positions to become a coordinator of nursing education for that unit and the Geriatric Assessment unit, which changed the

participants of my network and took me further away from the work of patient care. During this time I completed the American Rehabilitation Nurses Certification Course in Rehabilitation Nursing. An early portion of the course focused on models of team functioning. This study encouraged me to think more critically about the multidisciplinary approach and how the team could be used more effectively through a greater understanding of each other's knowledge and work and development of collaborative relationships.

The next stop in my lifelong learning quest was a Masters' degree in Nursing at the University of Saskatchewan, where I introduced myself to qualitative research methodology, and soon I embraced that as an approach to knowledge acquisition that made intrinsic sense to me. The Masters' degree led me to become a faculty member in the University Of Saskatchewan College Of Nursing where I still work and have a fulfilling professional practice that also provides clinical learning areas for the students. It was the collaboration in the small communities I lived in and the practice based in my previous rehabilitation experience that led me to want to study interprofessional collaboration.

My professional practice focuses on independently living but largely marginalized seniors and their health promotion. Research into health practices of community-dwelling senior women in Saskatoon showed a colleague, Peggy MacLeod, and me that older women viewed their health holistically and that their health could not be separated from the community. For a while my work broadened to the community, encompassing all age groups but during the time of research it was narrowed to be based in work with seniors only. To illustrate the merging of my two interests, I was president of the Board of the Saskatoon Council on Aging and also on the board of the Rainbow Community Centre, a grassroots community development group in Saskatoon's core neighbourhoods. I enjoyed the ambiance and people of these neighbourhoods

when I had the opportunity to be there.

Within that professional practice I was associated with diverse organizations and agencies, all set up to provide the specific services needed in an inner city area. This intersectoral work started with my first foray into working with marginalized seniors through my association with the Saskatoon Council on Aging, the Saskatoon Housing Authority, the Saskatoon Health Region, and transportation companies in my professional practice role as a faculty member. The number and variety of organizations that I interacted with on a regular basis escalated. Unfortunately I cut back on the work in the core neighborhoods as we prepared a new curriculum and I was engaged in this doctoral research. The significance for this study is that I value collaboration amongst professionals and organizations as the most effective way to improve health and quality of life.

As a faculty member in the College of Nursing I was also involved in the development of our two most recent curricula. For an earlier curriculum project I and my colleagues on the curriculum development committee were introduced to a consensus decision making process that proved to be effective for the collaboration of nurse educators from a variety of backgrounds including baccalaureate, diploma, practical, psychiatric, and Aboriginal nursing. This curriculum was deliberately set up to engender the attitudes, values and ways of acting that we, as faculty, wanted to see in our graduates. In my practice as a teacher, I continue to be both deliberately and unconsciously participating in the professional socialization of our students. Several of the values, such as caring, diversity, critical thinking (with emphasis on critical social theory as its basis), and participation guided my practice and clinical teaching experiences in the core neighbourhoods.

At the time of this research I was involved in the College of Nursing Undergraduate

Education and one of its subcommittees for Interprofessional Collaboration. As a faculty we embraced, among other principles, those of interprofessional practice and social justice. The principles of this curriculum run through the courses and were to be included, to greater or lesser degree in each course depending on the relevance to the course. Because interprofessional education is a key part of the curriculum, this committee also recommended specific courses that should or could be taken with students from other professions, one of which I developed and am teaching.

As a teacher I am intrigued by diversity among the students, especially in their approaches to learning. My consistent aim is to increase each individual's confidence in his or her own capability as a nurse. The nursing students that worked with me in a class on 'community health clinical' when I taught it, were assigned to collaborate on projects with the various organizations I was associated with in my professional practice. Unfortunately there is not yet a mix of interprofessional students but the area does beg for interprofessional practice.

Through this context runs the theme of relationships among diverse individuals and groups. While differences may lead to conflict and turf protection, especially for those who are competing for limited resources such as high marks or funding for their favourite projects, they can also be effective and creative in reaching common goals (verbal communication Giselle Doell, Friendship Inn). At the time of writing the research proposal these groups were in a new phase of constructing their relationships with each other through the formal networking group they had begun. One's social identity was influential in the success of these groups and affected the success of this initiative depending on whether one saw one's role as primarily protector of resources or collaborator and sharer. My preferred approach is to collaborate and share. This orientation influenced my evaluation of the stereotypical working styles of different health

professions that were briefly discussed earlier in the chapter and are included as part of the journaling necessary to keep account of possible influences on the interpretation of the study findings. It also affected my choice of methodology, which was to ground the knowledge, or theory, in the reality of those participating in interprofessional practice. This approach hopefully made the findings of this study more significant to faculty and students in interprofessional education.

Significance of this Study

The significance of this study stemmed from the dearth of knowledge related to experiences that students of the health professions had with each other in interprofessional learning experiences and the meaning of this for them. Collaborating in learning and work involves building and maintaining relationships as can be seen from the description by D'Amour et al. (2005). Research is needed to understand how students perceive and understand the experience of working in these relationships. Gilbert (2005a) stated that knowledge of the benefits of collaborative relationships among students was "elusive" (p. 35). An added complication was that not only were faculty involved in professional socialization; the health professionals that students met in clinical practice also played a significant role. This influence was apparent from the journaling of our senior nursing students who were eager to belong to the group of registered nurses that, as preceptors, guided their work in final clinical practice. We do not know all the ways in which health professionals and workplace structures influenced the maintenance and entrenchment of the entry level stereotypes.

Most of the published studies relating to interprofessional education and socialization were evaluations of new short courses encouraging collaboration amongst various mixes of health profession students (Glen, 2004; Paradis & Reeves, 2013) Many of the earlier studies

lacked the rigour required for formal research studies, due to the lack of comparison groups to show that the courses did or did not contribute to Interprofessional Collaboration (Zwarenstein, et al., 2000; Zwarenstein et al. 2005).

We could, and perhaps should, borrow knowledge from the related work of other disciplines and professions, and build on learning from our past experiences. It is important to have an understanding from our own field of professional practice, that is, health care. Because the research is still developing in this area it is useful to start with exploratory qualitative methodologies that can supplement the positivist findings and contribute to theoretical understanding upon which interprofessional educational strategies may be based.

Limitations of the Study

During the conduct of this study, several limitations with relevance for the study's findings, conclusions and related implications became evident. These are described as follows:

1. Six interviews were conducted, lasting an average of one and one-half hours, though the criteria established by Crist and Tanner (2003) called for three interviews per participant that including: *1:* history and description of experience; *2:* participant perceptions of the phenomenon; and, *3:* confirmation of researcher understanding of the participants' experience. Prior to the interviews, I had been involved with, and acquired some knowledge of, this community in my teaching role. At the outset of the study, I held meetings with the SWITCH Coordinator and Board, and an extended initial conversation with the participant group, during which I made them familiar with the nature of the study and the major considerations that were to be addressed during the interviews. At that time, social justice and experiential motivations of participants became apparent, and they became familiar with the study. It was determined that, in light of these activities, and in the interests of scheduling, one longer interview per participant

dealing with all three of the above content areas would be more expeditious. Nevertheless, the departure from the multiple interviews approach is identified as a limitation, given the possibility that it constrained the ability of participants to more fully recount, and provide elaboration on, their experiences.

2. The participants in this study were all students. During the interview period, they were, however, at varying stages of experience, knowledge and growth within the context of care and interprofessional practice. Though it was not my intention to convey the impression of participant uniformity on these qualities, readers of the findings should be aware that the only common element among these participants was that they were students at various stages of preparation for the health professions (mostly within the 'advanced beginner' and 'competent' levels of Benners' (1982) Stages of Growth. This was a natural outcome of my selection criteria which required simply that the participants would be students who had acquired experience as members of the interprofessional team at SWITCH (Student Wellness Initiative toward Community Health). Consequently, there was an unevenness of competencies and experiences among them, and this constitutes an inherent limitation of the study.

3. This study was based upon retrospective descriptions by participants, of their experiences of interprofessional relationships. The study was limited, therefore, by the willingness honesty and ability of participants to fully recall events, and to describe experiences and their reactions to them.

4. The data collection, my presentation of the voices of my participants, and the related conclusions and implications I drew from them were dependent upon my own understanding and interpretation of the basic concepts underlying hermeneutic phenomenology. The uncertainty regarding my own complete understanding of Heidegger's complex philosophy,

represented mainly in his works: *Being and Time* and *Time and Being*, was exacerbated by the reality of these works as translations, and my nagging uncertainty as to the influence of language and culture on their meaning and my own interpretation.

5. There were inherent limitations in the use of Heideggerian concepts. They had major implications for this study in that they provided the structure by which interviews were designed and, it follows, in the types of evidence, specifically participant sense-making, upon which the study's findings and conclusions were based.

Delimitations of the Study

1. This study was based upon Heideggerian perspective, and was consequently restricted to that particular lens on the students' experiences. Other perspectives were not considered. The title of this dissertation and its statement of purpose have been structured to reflect this delimitation.

2. This study was delimited to the analysis of the experiences of six students in interprofessional relationships in a clinical setting. The experiences of others involved in this activity were not considered.

3. Given the structure of the participants' time and working commitments, data collection was limited to one interview with each participant. On average across the six participants the Interviews were 90minutes in length. Upon conclusion of the six interviews, I was satisfied as to the richness of the data and the quality of these participants' accounts and recollections based upon the Heideggerian concepts that constituted the focus of my questions.

4. Experiences that were the focus of this study were delimited to those that occurred in an inner-city health care setting, within one student-governed interprofessional health care initiative. SWITCH (Student Wellness Initiative toward Community Health).

5. Students in the university nursing program did not participate in this research because I either taught or would teach all of them, a situation which would require a higher level of ethical strategies. During the data collection I did not meet or recruit nursing students.

6. All six of the participating students were women. The findings related to the experiences of these students were based upon the perspectives and meaning-making of these selected female students.

Organization of the Dissertation

Chapter II is focused on the publications concerning experiences with and research on, interprofessional education. This provides a reference point on which to base the methodology. The methodology, described in Chapter III, emerged from the study purpose, my knowledge, and the literature. It also reflected the context in which the relationships to be studied were developed. Because qualitative research is not based on hypotheses and its data collection and analysis are concurrent, the research strategies were flexible in order to respond to ongoing findings and the unstable nature of the context. While the methodology served as a starting point and guide, adaptations were made to suit the needs of the participants and the setting.

These first three chapters comprised the discussion of the literature search related to the development of the questions that guided the research for my dissertation (Chapter II) and the methodology decisions (Chapter III). In Chapter IV the context of student participants' volunteer work and the findings from the interviews are discussed, enhanced by quotes and perceptions of the volunteer participants. Chapter V consists of an analysis of the factors related to credibility, as well as my perspective on the research process and findings.

CHAPTER II: LITERATURE REVIEW

The purpose of this research was to gain understanding of the relationship experiences of health profession students in a context of interprofessional clinical practice. This chapter consists of a review of the literature related to interprofessional education. It begins with a discussion of existing literature reviews of interprofessional education and collaboration in health care. Because the desired outcome of interprofessional education is effective collaboration among professionals a discussion of the perceived requirements for collaboration follows. The chapter concludes with a discussion of the literature related to interprofessional education initiatives, with emphasis on issues, barriers and facilitators.

Published Reviews of the Interprofessional Education Literature

In spite of the emphasis on interprofessional collaboration in the literature, initially there was little in the literature to provide the evidence that interprofessional education initiatives actually prepare graduates for the relationships necessary for effective interprofessional practice (Barrett et al, 2003; Zwarenstein et al. 2000; Zwarenstein, Reeves, Barr, et al. 2005a). Two major reviews of the literature in this area have been published by the Cochrane Library. Cochrane reviews are systematic reviews of the literature and unpublished studies to evaluate health care interventions. The inclusion criteria generally privileges random control trials although the Cochrane Handbook does include a chapter on using qualitative research in the reviews (Higgins & Green, 2008).

In 2000 the first Cochrane review of studies related to interprofessional education in health care for improvement in practice was undertaken using selection criteria that required the methodology to include randomized control trial, interrupted time series, or controlled before and after studies (Zwarenstein et al., 2000/2005a). This review team did not find one study of

interprofessional education or collaboration in over 1,000 that met the criteria necessary to use the findings (Zwarenstein et al.). In addition to the problems with quantitative studies, qualitative data reported in this were often gathered through open-ended questions added on to the quantitative questionnaires. This practice limited the depth of insights related to interprofessional education.

The second Cochrane review team (Reeves et al. 2008) had the same inclusion criteria as the first and found six studies that met the criteria, four of which showed positive or positive and neutral effects while the remaining two demonstrated no effects. Each of the four studies with significant change reported a different positive result: improved patient satisfaction; improved workplace culture; improved team behaviour; and, competency in teamwork, holistic approaches, education, rehabilitation or overall competency. All of these research projects focused on post-licensure as opposed to pre-licensure, collaboration. The review team concluded that researchers must continue to use rigorous methodologies and to use data collection strategies that will show how the project produces or does not produce change.

An update on the second Cochrane review found nine new studies that demonstrated positive results in the areas of treatment of specific issues and in team functioning. The team stated that due to the small number of studies, 15 in all, it would be premature to say that interprofessional collaboration improves care outcomes overall. The team recommended more rigorous research in the areas of effectiveness of IPE, cost-benefit analyses and qualitative components looking at IPE processes as well as processes related to improved practice.

Zwarenstein, Reeves and Perrier (2005) contrasted the findings of pre-licensure IPE literature with that of the post-licensure research. They found that only the post-licensure literature showed positive results but noted that it is very difficult to evaluate pre-licensure

projects with any degree of rigour due to the complexity and scale required in the design. In order to have random control trials the researchers would need to involve several institutions, each with several faculties participating. Finding enough universities with the full commitment to interprofessional education in the health profession faculties would be a challenge. Controlled before and after studies would also require the participation and commitment of multiple faculties, and they would need to structure for similar IPE experiences. Following the participants from their educational programs into practice would be fraught with difficulties because they would be in various health care settings, not all of which would support collaborative practice, depending on the social environment of the agency.

The review of the IPE literature for this research project was consistent with the findings of the formal reviews discussed above. It showed that most IPE study results were actually course evaluations of short projects undertaken for the first time. Kilminster et al. (2004) stated that most IPE 'research' tends to be "small scale, one-off pilot projects and evidence of their effectiveness can be difficult to establish" (p. 718). This view was supported by Barrett et al. (2003) who pointed out that the effect of these projects on practice is not known. This issue relates back to the difficulty with the evidence base that Zwarenstein et al. (2000/2005) found. Pirrie et al. (1998) had a different perspective. They agreed that evaluation of the programs was not satisfactory but they believed that the perceived benefits provided ample evidence that IPE should go ahead. The remainder of the literature focused on the needs of interprofessional education and the barriers and facilitators to meeting these needs. Those who published course evaluation papers also made recommendations for teaching strategies and placement of IPE experiences in the curricula and learning environments. Teaching strategies selected should be consistent with achieving the goals and preferred outcomes (Oliva, 2006; Posner & Rudnitsky,

2006). For this reason, a discussion of the characteristics of the overall goal of IPE, collaboration in practice, follows providing a perspective from which to consider the published research and project findings in the area of IPE.

Interprofessional Collaboration in Health Care Delivery

The desired end product of IPE is interprofessional collaboration, based on the belief that collaborative relationships produce more effective and efficient health and social care. Henneman, Lee, and Cohen (1995) described collaboration as a complex process requiring competence and confidence. Craven and Bland (2006) stated that collaborative care involves providers from different specialties, disciplines, or sectors working together to offer complementary services and mutual support, to ensure that individuals receive the most appropriate service from the most appropriate provider in the most suitable location, as quickly as necessary, and with minimal obstacles. Collaboration implies communication, close personal contacts, sharing of clinical care, joint educational programs, and (or) joint program and system planning (p. 9S).

Within this definition is an implication that several skills are necessary for collaboration to be successful. Most of these skills relate to working effectively in teams. Glen's paper recommended teaching about the differences and similarities in values, in tolerance, in negotiation, and in dialogue, as these were seen as underlying appreciations for working together in a value laden environment such as health care (2004).

Many authors have attempted to understand collaboration in health care settings through applying existing theory to real or hypothetical situations, both pre-licensure and post-licensure. Much of the literature related to collaboration in health care and pre-licensure education is based on what is known about team work, organizational theory, and organizational sociology (San

Martin Rodriguez et al., 2005). Several authors provided recommendations for successful collaboration: the organizational and environmental components, as well as attitudes, relationship concepts and knowledge. The major concepts from this literature will be discussed under the following concepts of working together, communication, knowledge, and, respect and trust.

Working together.

The first organizational requirement is that in order for interprofessional collaboration to occur, members of different professions must work together (Craven & Bland, 2006). Reeves & Lewin (2004) found in their study of a medical ward in England that the more closely professions worked together the more likely collaboration was to occur, and that the less contact the professions had with each other the less likely they were to form cooperative relationships. Reeves and Lewin also found that the organization of health care delivery in this hospital was more likely to produce transient working groups than collaboration. For example, when consultants had patients on several different units, resulting in their attention being divided among various work groups and patients, they collaborated less.

Reeves and Lewin followed up their 2004 study with another that observed interactions on the units and found that staff interacted with each other on the basis of specific professions rather than professional colleagues (2011). They also found that the fast moving environment in acute care was not conducive to the development of collegial collaboration even though they were working together. The shift rotations were also thought to be problematic for collaboration when each profession had its own way of scheduling workers resulting in less frequent contact between individuals that made it difficult to build collaborative relationships and processes.

McCallin found that conflict in working together was a barrier to collaboration (2001).

She cited inflexible professional boundaries as a source of conflict. Brooten, Youngblut, Hannan, & Guido-Sanz (2012) indicated that the professionalism of the physician, especially related to the traditional hierarchical relationships, had more influence in relation to conflict than gender differences did. Team building was not seen as a sufficient antidote for conflict. They also stated that the perceptions of interprofessional collaboration were also related to environment in the specific health care setting. Lingard, Espin, Evans, and Hawryluck found that competition for resources could also impair team collaboration (2004). They saw negotiation as an important strategy to avoid this conflict. Overall, conflict resolution is an important skill set to promote effective working together in collaborative practice.

Close contact.

Glen (2004) found that close contact provides opportunities for discussion, and that informal discussion that helps professionals know and understand each other is more likely to occur if they are working together over time. Informal discussion has also been found to be conducive to commitment, a sense of belonging (D'Amour et al. 2005) and shared goals (Henneman, et al., 1995).

Working in close contact increases the opportunities for cooperating in care together (Weinberg et al, 2011). This proximity in care provision also increases the chances of disagreements arising. Lamb and Shraiky (2013) advised that physical spaces must be designed to promote contact and interaction. Henneman et al. (1995) and Lingard et al. (2004) pointed out that conflict resolution was often considered a tool to improve collaboration. Lingard et al. saw collaboration as requiring assertiveness as well as cooperation and considered these two skills to be extremely important in conflict management. Glen's recommended approach for working together effectively included tolerance, negotiation, and dialogue, as a way of facilitating

cooperation in the face of different knowledge bases, value systems, and approaches to care (2004).

Joint participation.

Joint participation in care (Craven & Bland, 2006) also is more likely to produce shared goals as well as shared responsibility (D'Amour et al. 2005; Hall, 2005). D'Amour et al. noted that those providing care together may also create their own ways of structuring that care provision. Governance was an issue that was identified by D'Amour et al. and is related to shared decision making, power, and authority (Henneman et al., 1995) and equal status (Hean & Dickinson, 2005; Oandasan & Reeves, 2005). Weinberg et al. (2011) included the need for organizational support of teamwork and noted that lines of authority influenced the amount of collaboration that took place. Issues related to status will be discussed in the barriers section.

Communication.

Communication is key to collaboration (Bruner, Davey, & Waite, 2011). Part of communication was seen to involve negotiation of aspects such as roles, care structuring and governance (King & Ross, 2003; Reeves, Nelson, & Zwarenstein, 2008). Oandasan & Reeves found conflict resolution skills to be an important part of communication in collaborative practice (2005). Competence in dialogue as well as discussion was thought to be a helpful communication skill in that it shows respect for the other (Glen, 2004). Knowing and understanding other professions and the individuals in them were thought to assist with making communication more appropriate and specific in its intent and outcome (Clark, 2007; Harriet, Cummings, & Springer Dreyfus, 2003; Howell, Devine, & Protsman, 2004; James, 1997; Salfi, Solomon, Allen, Mohaupt, & Patterson, 2012).

Knowledge.

According to Clark (2007), "the power of each health care profession is based on the mastery of and the ability to generate and utilize, specific types of knowledge" (p. 581). Knowing the knowledge base, skills, roles, and scopes of practice of the other health professionals one works with enhances the understanding of what each individual may contribute and ensures that all collaborators are being integrated into the care provision in the most effective way (Duner, 2013; Kilminster et al., 2004; Leaviss, 2000; McDaniel, & Robertson, 1997; Mu, Chao, Jensen, & Royeen, 2004; Reynolds, 2003; Wakefield, Furber, Boggis, Sutton, & Cooke, 2003). Clark labeled this "The Cognitive Map of the Profession". He also noted that it is important to understand the normative map of beliefs, attitudes, and values of other professions: "If members of an interprofessional team do not have a basic understanding of the cognitive (and, I would argue, normative) maps of other professions, then they may *look* at the same thing but not *see* the same thing" (p. 582). The differences among the professions are important to health care provision but in order for collaborating groups to capitalize on these differences they must have a working understanding of each other. This understanding is critical to respect and trust among the collaborating professionals.

Respect and trust.

Respect for each other was also seen as important (Barr, 2013; Bonifas & Gray, 2013; Hale, 2003; Henneman, et al., 1995; San Martin Rodriguez et al., 2005). Respect can be developed through understanding each other's knowledge and capabilities for the collaborative team. This knowledge must be accompanied by respect for each other's values and beliefs as well as modes of response to patient or client needs (Engel & Prentice, 2013; Glen, 2004). Closely connected with respect and understanding is trust, another requirement for working

collaboratively (D'Amour et al. 2005; Ewashen, McInnis-Perry & Murphy, 2013; Henneman et al., San Martin Rodriquez et al.). It is difficult to have either trust or respect without the other.

Glen (2004) observed that in our educational programs we taught students to be "a doctor or a nurse, not to do doctoring or nursing" (p. 208). This statement is consistent with that of Clark (2007) and Engel and Prentice (2013) in that we must understand and respect the values and approaches of each profession as well as the knowledge, in order to work together effectively in providing care. Arredondo, Shealy, Neale, & Winfrey (2004) recognized that sharing in work and understanding with others from different backgrounds might take professionals out of their comfort zones. It would be difficult to expect new graduates to collaborate effectively if they had neither understanding nor skills for IPC at entry to professional practice. Being prepared with the skills through IPE would be a more efficient way of preparing health professional students for professional practice.

Interprofessional Education

Learning together through portions of the pre-licensure education programs can not only assist with the acquisition of skills required for collaboration but also the understanding that Clark (2007) and Glen (2004) wrote about. In their study Pollard and Gilchrist (2004) found that although students positively rate their acquisition of skills for collaboration they were not positive about interprofessional interaction. Interestingly they found that the most negative views came from those students with higher levels of education. They postulated that the reason for this finding might be related to the students with more education having more exposure to the differences in power and status among health professionals in health care practice. In a later study, Mires and Pollard (2009) found that licensed health care professionals understood the importance of interprofessional work but that there were frustrations with differing priorities and

ways of meeting them among the professions involved. The differences between the two research groups may relate to the challenges that new graduates have in adjusting to the role of health professionals.

Officially in Health Canada, the definition of interprofessional education used is a revised version of that put forward by the Centre for Advancement of Interprofessional Education (CAIPE): “occasions when two or more professions learn from and about each other to improve collaboration and the quality of care” (CAIPE 2002, Oandasan et al. 2005, n.p.). This is a very broad definition that does not highlight any of the knowledge, skills, or attitudes considered necessary. Furthermore it does not specify the requirements of the context in which interprofessional education may be more effective. Arredondo et al. (2004) were more specific than CAIPE and Health Canada in their definition of interprofessional education:

> interprofessional education refers to education, training, scholarship, practice and other professional activities that prepare and call for psychologists to work: (a) in a respectful, collaborative, integrative, and informed manner with other psychologists and members of other disciplines and professions; and (b) with individuals, groups, systems, and organizations that may have diverse values, ethical perspectives, or worldviews, and accountability to different constituencies” (p. 788).

This definition of interprofessional education included recognition of some of the skills and attitudes discussed above, but had an added description of the contexts in which collaboration occurred outside of interprofessional education. The early literature describing IPE initiatives was based on projects that took place in settings that are consistent with these contexts: hospitals, a focus on care of the individual, and in the community where specific groups were considered. The issues that accelerated the change to collaborative practice were system based, such as the interprofessional tension

between doctors and nurses in the Canadian case (Ceci, 2004a; 2004b) and the gaps in follow-up in health and social care for the child who died of abuse in England (Meads and Ashcroft (2005).

Requirements for interprofessional education.

CAIPE identified three key requirements for effective interprofessional education in their principles upon which these endeavours should be based (2002). Their first principle, that interprofessional education "works to improve the quality of care" (n.p.) acknowledged the complexity of services and care such that no one profession can expect to provide adequate assistance alone. The second principle, "focuses on the needs of service users and caregivers" (n.p.) clarified that the service user and his or her caregiver were the centre of attention. In addition to this the third principle, "involves service users and caregivers" (n.p.), stipulated that the people for whom services were to be provided must be involved as participants at all stages of the care in order to ensure their needs were met.

The fourth and fifth principles from CAIPE for interprofessional education, "encourages professions to learn with, from and about each other" (n.p.) and "respects the integrity and contribution of each profession" (n.p.) focused on the relationships of the professions (2002). Inherent in these principles was recognition of the need for knowledge of the work of each profession, the importance of mutual trust, and respect and equality of all as learners. Interprofessional education was also seen as an opportunity to experiment with interprofessional practice.

In the final two principles, "enhances practice within each profession" (n.p.) and "enhances professional satisfaction" (n.p.), CAIPE (2002) addressed the outcomes of

interprofessional practice for the professions and their members. Practice within the individual professions was expected to be enhanced due to consideration of each profession's work in relation to that of others (Wenger, 1998). The same mechanism would lead to a better understanding of, and satisfaction with, one's own profession through shared support and guidance. The praxis that occurred as a result of interprofessional learning in IPE contexts not only engendered respect for all professions but for the service users as well, with the product being a more satisfying experience (CAIPE, 2002).

Goals for interprofessional education.

Other literature in this area is consistent with the above-mentioned principles. Leaviss (2000) stated that increased knowledge of the roles of other health professionals was important not only in the interrelationships to promote trust and respect for each other, but also to decide who was the best person to be involved in specific aspects of care. Hale (2003) believed that learning together about each other would result in reciprocal attitudes and perceptions conducive to collaboration. This change was to lead to mutual respect and was believed to have the potential to enhance care through appropriate referrals (Leaviss, 2000). Leaviss saw this growth in understanding as increasing competence and confidence in interprofessional relationships. Kilminster et al. (2004) and Leaviss (2000) believed that it also resulted in effective teamwork. Each of these projected outcomes is consistent with the perceived requirements for collaboration.

Timing of interprofessional education experiences.

Situating IPE within the curricula continued to be controversial. The three most common options discussed were a common foundational year, integrated throughout the

curriculum, or at the end of the program. The reasons cited for selecting an option were related to professional identity, stereotyping, or relevant learning experiences.

Wood (1999), who researched interprofessional education related to the construction industry at Leeds Metropolitan University, put forward a more radical idea that was a common foundational program in which students would develop specialization in the last half (two years). Mazhindu (2001) explained that in England there was considerable political support for such education for health professionals but that the health professions were not in favour of this concept from a logistical, identity, and scope of practice perspective. Makino et al. (2013) found that students from different professions taking a first year lecture style course together were more negative about IPE than students in later years who were learning together through practice. The researchers hypothesized that IPE was more effective when offered within a clinical setting however the group in the study that had graduated and worked in professional roles had more negative responses in relation to the efficacy of team work. Perhaps this response was related to disenchantment due to more experienced professionals not having grasped the collaborative approach yet so that what they saw was not what they expected.

McFadyen, Webster, Maclaren, and O'Neill, (2010) found lower scores for IPE as the educational program progressed. They hypothesized that the positive scores for IPE in the earlier levels of the curricula were related to idealistic attitudes toward working together and that waning idealistic expectations over time may have been responsible for their research results.

The alternative of integrating interprofessional education throughout the curricula with or without the common foundational year was also presented in the literature. One

of the bases of support for this approach was that extended contact with each other results in more attitude change and that client care is enhanced (Mu et al., 2004). Mazhindu (2001) was in favour of a design that integrated interprofessional learning throughout the curricula. Ansari, Russell, & Wills, (2003) recommended that the interactions and learning be increased in complexity as students progressed throughout the curriculum. Salfi et al. (2012) then laid out the progression of skills and knowledge necessary for collaboration throughout a Bachelor of Science Nursing program.

The students that Pirrie et al. (1998) studied wanted to develop their professional identities and thus become engaged in their professions before they had too much interprofessional education. For this reason the authors recommended that the bulk of interprofessional learning be integrated throughout the program with more emphasis on the latter stages when professional identities would be better developed. This desire for the introduction of skills building upon previous skills throughout the education process was reflected in the program for collaboration that Salfi et al. (2012) proposed. It started with familiarization with and socialization to, the roles of their own chosen profession and group work before moving on to interprofessional learning. In other words, there were some concepts and skills that needed to be learned before others.

The third option that of providing the interprofessional education experiences in the latter stages of the programs was based on the belief that students needed to avoid blurring of roles and therefore needed to have their professional identities and socialization completed before they engaged in practice with students of other professions. For the students, interprofessional experiences based in realistic practice situations (either with simulated patients or through problem-based learning) were highly

relevant at this time leading the authors of these studies, Freeth and Chaput de Saintonge (2000) and Kilminster et al. (2004) to declare it perfect timing. However, their studies did not have any comparison groups so they could not show evidence of interprofessional work at any other point in the student programs thus, they could not support their assertion.

Ansari, et al. (2003) described a need to increase interactive complexity in IPE, or collaborative learning experiences, among health profession students and teachers. Wood (1999) studied interprofessional education outside of the health professions and came to the same conclusion. Similarly, Gilbert made a distinction between exposure, and having students learning in the same location or in interspersed episodes, and immersion, a more intense involvement. He recommended that the immersion should come in their final year: "By their year of graduation, students have experienced a sufficient complexity of clinical cases that they recognize their shortcomings and the shortcomings of their profession in managing problems beyond their scope of practice" (2005b. p. 100). He noted that early exposure to the concept and basic skills of IPC is an important developmental step for immersion into collaborative practice. In addition, Wilhemsson, Svensson, Timpka, and Faresjö (2013) found that professionals who were educated through an interprofessional curriculum were more confident in their professional interactions. This is an important point because communication represents a critical element in effective collaboration.

Teaching-learning strategies.

While there was some division of opinions related to the introduction of interprofessional education early on, the teaching-learning strategies recommended all had a common theme, that

of being interactive and grounded in realistic practice situations. This could be clinical experience (Harriet et al., 2003; Howell, et al., 2004; Mu et al., 2004; Rose, Lyons, Miller, & Cornman-Levy, 2003), problem based learning (Freeth & Chaput de Saintonge, 2000, Reynolds et al., 2000, Wakefield et al.2003); case-study (Ansari et al, 2003), or patient simulation (Kilminster et al., 2004). These approaches provided relevant experiences and opportunities to work with each other in their specific professional roles. Later literature focused on a progressive integration of knowledge and skills throughout the curricula (Mazhindu, 2001 & Salfi, et al., 2012). The students were positive about what they learned about each other and clinical practice.

Two researchers found differences among the students in their levels of comfort with learning strategies. Horsburgh et al. (2006) found a difference in preferred learning approaches. Nursing students were more attracted to collective learning, preferring teamwork, while medical students tended to see learning as an individual's responsibility. The pharmacy students in this study were mid-point between team and individual preference. These differences mirror the gender related choices found by Reynolds (2003). Women in this study were found to prefer learning from other students while men were partial to lectures.

Outcomes of interprofessional education projects.

The outcomes of these studies were mostly positive although there were differences in perception among various student groups in some studies, one of which has been discussed previously: the lower satisfaction expressed by medical students in Tunstall-Pedoe et al.'s research on the common foundational program (2003). In McDaniel and Robertson's (1997) research the nursing students were slightly more positive about the effectiveness of the clinical experience than were their pharmacy counterparts. The negative feedback in that study was related to the environment. While the students' evaluations in Howell et al.'s study (2004) were

mostly positive the occupational therapy students were disappointed that the negative stereotyping of occupational therapy on the part of the physiotherapy students did not improve. The occupational therapy students were at an earlier level in their program than the physiotherapy students, a factor that may have been an influence on the attitudes of the physiotherapists. Wilhemsson et al., (2013) found that nurses who had graduated from an interprofessional educational program were more confident in both their interprofessional interactions and their nursing role.

The faculty in two projects (Mu et al., 2004; Rose et al., 2003) had goals of improving student attitudes to the marginalized clients they were working with, as well as toward each other. The student attitudes to working with each other were positive in both projects but the outcomes in relation to the clients differed between the two initiatives. Mu et al. (2004) found that respect for Native Americans did improve in relation to the length of time that their students spent in providing health care to people on a reserve. Three of the students went back to the reserve to practice upon graduation. Rose et al. (2003) found a somewhat different outcome in that the attitude toward the homeless and indigent people that their students worked with only showed moderate improvement. Another of their goals, developing student leadership abilities, did not appear to be met in that there was no perceived change in skills.

As stated previously, much of the early work discussed above is based on literature related to evaluations of single trials of specific strategies for learning about collaborating interprofessionally. The literature about instituting IPE programming tended to focus on the barriers to the initiation of these projects rather than the facilitators. Overall the barriers and facilitators were relevant to large scale projects such as common foundational years and integrated curricula. The later studies and reviews incorporated more theory based and stringent

methodologies (Paradis & Reeves, 2013).

Structure as barrier to interprofessional education.

Craven and Bland (2006) pointed out that focusing on skills for collaboration is not enough; context is also important. Educational and professional structures must not only support, but promote collaboration. Research related to IPE and IPC must be reported as situated in the context in which it occurs (DeMatteo & Reeves, 2013) so that successful strategies and structures may be repeated by others and detrimental factors may be avoided. The emphasis in the IPE literature on barriers was related to the need to involve multiple organizational and professional organizations. The complexity of these administrative challenges is difficult for those attempting to introduce interprofessional education (Gilbert, 2005b). The barriers range from administrative differences in professional and program entry requirements and curricula to components of social structures such as professional socialization and identity and gender roles.

Conflicting professional entry requirements.

One of the most obvious structural challenges to interprofessional education is that each health profession has its own entry level specifications for licensure (Hale, 2003) that may vary from province to province. Physicians in Canada require ten to 14 years of education, including, in many cases, substantive work on a degree prior to entry in medicine. Beginning in 2010 all physiotherapists in Canada required a Master's degree to enter practice. Social workers on the other hand may enter practice in some provinces with a two year diploma (Canadian Institute of Health Information, 2006). Nurses require a Baccalaureate degree to enter practice in most provinces in Canada, however Quebec will still license new diploma graduates (Canadian Nurses Association, 2014) and the Yukon does not have any programs. These inconsistencies may produce problems with democratic decision making, common language, and mutual respect.

Added to the mix is the relatively new profession of Nurse Practitioners with different entry to practice requirements due to the provincial jurisdiction of educational qualifications (Canadian Nurses Association 2009). Gilbert (2005b) found that technical language differences among the professions based on years of education created an asymmetry in their working relationships.

Differences in educational qualifications may therefore perpetuate the health care hierarchy based on educational qualifications for nurses. In the health care institutions those who work most closely with patients in institutional settings often have the least education. It is only relatively recently that a university degree has become a requirement for entry to nursing practice (Canadian Nurses Association (2004), but Coombs (2004) and Coombs and Erser (2004) found that social and emotional knowledge about the patient was less regarded as relevant to the patient's health needs in an ICU by the doctors or those with higher education- who spent less time with the patient. Rice et al. (2010) found, in a Canadian study, that doctors were less cooperative with the researchers' introduction of an IPC strategy involving a new intervention based on communication.

***Program entry requirements*.**

In addition to the education exit points of the various groups listed above, entry requirements for various programs often differ. Some are required to have a previous degree while others enter straight from secondary education programs. This difference, in addition to the individual curriculum frameworks guiding the various programs, results in students having different levels of knowledge in the same year of their programs. An example of the different levels of education is that medical and nursing students must have some previous university courses before they are admitted to the medical programs yet in Saskatchewan, entry to Physiotherapy requires a baccalaureate degree as well as a Master's degree in Physiotherapy to

enter practice. There is a significant difference among the programs. Medical and nursing students both in year one of their respective programs, would have vastly different prior learning and life experiences than medical students. Scheduling effective pre-licensure interprofessional educational experiences for all of these groups, while ensuring an optimal match in educational level requires high priority commitment of all partners (Gilbert, 2005b).

Teaching-learning requirements.

This barrier is related to the belief that small, interactive group work is most effective for teaching collaboration (Barr, 2013; Barrett et al., 2003; Tunstall-Pedoe et al., 2003). Small groups are conducive to a constructivist approach to interprofessional education in which professional identities may be explored and built upon (Hean, Clark, Adams, Humphris, & Lathlean, 2006). However, small groups are an expensive proposition for the educational institutions, which may be hoping to save money through larger format classes of IPE (Gilbert, 2005b). Collaboration issues included decisions about the professional role modeling and expertise that is seen to be necessary for each student group. If each group required a teacher from each profession represented by the students each time they met, the cost would be increased and likely prohibitive. This potential expense could affect the quality of the educational preparation of health professional students for collaborative working relationships (Gilbert, 2005b).

Curriculum differences.

Each professional education program has its own curriculum, further challenging the timetabling and decision-making. Some curricula have IPE and collaborative concepts integrated at different levels throughout the curriculum while others may have it in discrete courses. These differences may result in first year social work students working with second year physiotherapy

students, third year nursing students and fourth year medical students, giving a mix of students at differing levels of maturity, knowledge, and professional socialization, thereby increasing the complexity of the interprofessional education task. Howell et al. (2004) found that having students at different stages of their programs practicing together was problematic, though this, of course is a reality for most university programs. Addressing this problem can be quite difficult with multiple independent curriculum committees.

In their study of a common foundational year for students of several health professions Tunstall-Pedoe et al. (2003) found that although all students were in the first year of their program the medical students stood out. The medical students were less positive about the experience than the others, feeling that they had been taught inappropriate skills and irrelevant information. Other students were negative about the medical students, describing them as less caring and dedicated, poorer in communication and teamwork, and more arrogant. More of the medical students entered their program directly and therefore were younger than the others.

Ten years after Tunstall-Pedoe et al., (2003) study, Doll et al. (2013) reported a study of an IPE intervention that involved students in their senior year of their programs making interprofessional decisions. The medical student in one group was surprised that students of other professions would take the lead in the team's work, assuming instead that this was the medical student's natural role. While this was the reflection of only one medical student in a single case study, the reaction was consistent with the hospital practice findings of Rice et al (2010).

Social and cultural barriers.

While teaching and professional administrative barriers were more obvious there continue to be social and cultural beliefs and practices discussed in the literature that are serious barriers. One of these issues was stereotyping which has been discussed previously. Others that

will be presented here are professional socialization, status, and gender.

Professional socialization.

Professional socialization itself is a structural issue. First, there is the possibility of teachers who have been socialized into the hierarchical system modeling the traditional roles and interactions that conflict with the more democratic power and decision making relationships espoused by proponents of interprofessional collaboration (Peile & Briner, 2001; Rice et al., 2010). Second, there are the conflicting views of when interprofessional experiences should be introduced in relation to the professional socialization process (Freeth & Chaput de Saintonge, 2000; Hale, 2003; Keshet, Ben-Ayre, & Schiff, 2013; Kilminster et al., 2004; Pirrie et al., 1998; Tunstall- Pedoe et al., 2003; Wood, 1999). There was an expressed fear that if interprofessional education was introduced before socialization to the professional role was well enough instilled into the students there would be a lack of understanding of professional roles and differences that would result in blurring of the professions (Pirrie et al., 1998). Wood believed that it was important to start the process from the beginning of the professional programs to ingrain interprofessional values before the professional socialization produces the traditional relationships. His proposal emphasized the commonalities among the professions first, then focusing each professional group on the differences. Recently there has been an emphasis on dealing with the differences in the value-laden cultures of the professions that perpetuate the hierarchical relationships believed to be an impediment to collaboration (Rice et al., 2010).

Hean et al. (2006) and Hean, Clark, Adams, Humphris, and Lathlean (2006) found that students entered programs with a sense of professional identities for their own, and other, professions pre-formed. They believed that through working together interprofessionally the students would continue to develop these identities. (One would hope that this would include a

critical perspective regarding stereotypes held for other professions). Hean et al.'s research supported the view that integration of IPE throughout the curricula was best. However, Hean, Clark, Adams, Humphris, and Lathlean (2006) cautioned that if the student's view of the value of his or her profession's traits was not congruent with the perceptions that other students hold of it, intergroup conflict might result. This perception was reinforced by Whitehead (2007) in her statement that if IPC was adopted without the physician retaining leadership and authority for the decisions made there would be problems with the procurement of doctors in collaborative environments.

Status differentials.

Whitehead (2007) suggested that the traditional hierarchy in decision making relationships may need to be maintained in order to engage medical schools and doctors in interprofessional education and practice. In Canada doctors enjoy higher status than other health care professionals, and have more political influence through their privileged relationships with institutional administration. When collaboration was seen as a democratic process that raised other team members up to the same status as the doctor, the doctor's status as the leader was perceived to be diminished. According to Whitehead, the possibility of losing relative status may decrease the medical profession's interest in interprofessional education and work.

In 1999 the federal government established the Office of Nursing Policy within the Health and Policy Branch of Health Canada. Nursing is the only health profession to have a designated office within Health Canada (Health Canada n.d.). Both the medical and nursing professions have now gained understanding of the expediency of working together. The Canadian Nurses Association and the Canadian Medical Association have collaborated in joint policy statements, such as the one for planning for health human resources (Canadian Nurses

Association & Canadian Medical Association, 2005) however the issues of hierarchy continue (Bruner et al., 2011; Rice et al., 2010; & Weinberg et al., 2011).

The status enjoyed by physicians may be threatened by the trend to patient-centred care (Oanadasan et al. 2005; Peile & Briner, 2001). Peile and Briner believed that as the work of health professionals became more centred on the patient, the privilege of voice would shift to those who work most closely with the patient and could be driven by the patient-become-consumer (DeMatteo & Reeves, 2013). In the hospital setting the people closest to the patients would usually be nurses and the patients in all environments would be the consumers. Coombs (2004) found in her research in an intensive care unit that the unique knowledge that nurses had was about the individual patient experience. This information was seen by the medical staff to be irrelevant in comparison to the clinical data.

In spite of the change in focus brought by collaboration and patient centred care, others found that doctors were still considered a critical element of health care team functioning. Zwarenstein et al. (2003) conducted a pre-post-test study in which the intervention was a course in interprofessional collaboration for health professionals on a British hospital ward. Measures of both effectiveness and efficiency were positively significant following the intervention, as was nurse-physician communication. Wells, Johnson, & Salyer (1998) studied the effect of the introduction of various collaboration methods on several hospital wards shortly after their introduction and 16 months later. They found that regardless of the strategy used, greater physician participation resulted in a stronger perception that collaboration was occurring. This finding was consistent with the belief that the doctors were the leaders of the team. Wells et al. (1998) recognized that in hospital practice especially, the participation of the physician was critical.

Russell, Nyhof-Young, Abosh, & Robinson (2006) found that nursing and medical students working in their senior practica did not have a functional understanding of 'team'. They could name the members of the team but could not explain what the team as a whole was expected to do and their perceptions of what they valued in teams differed. The medical students believed that input from other team members was important but that the doctors made the decisions. Nursing students focused more on the collaborative aspects of team work and felt that doctors should not be the major decision makers. However, when asked they stated that having their input taken into consideration was adequate for collaboration. This finding related to students was consistent with the belief that the physician is the key professional for collaboration, and this may well be related to the point that those with the legal responsibility for the decision should be the major decision-maker.

The Canadian Nurses Association and Canadian Medical Association stated that the divide between doctors and other health care professionals was perpetuated by the difference in funding mechanisms (2005). In their Green Paper: *Toward a Pan-Canadian Planning Framework for Health Human Resources,* the Associations pointed out that 98 per cent of physician services were publicly funded as well as most hospital services but that only 8 per cent of non-physician health professional services that were not covered by hospital employment were funded. They saw this difference impeding collaboration which was expected to occur on a more level playing field. This difference was related to status in that being able to work outside of the control of large organizations was seen as being more autonomous in practice and therefore higher in status.

Influence of gender differences.

Historical gender differences are part of the historical-cultural structure and have

contributed to the hierarchical structure of health education programs and health care services. Perlow, Gittell, & Katz (2004) stated that research related to the contextual influence on group work in organizations has been focused on the influence of macro-contextual factors on organizational structure or on organizational factors and how they affect measurement of group work. This implied that historical socio-cultural patterns influencing gender roles were part of the macro-context that affected how health care organizations were structured and how decisions were made within these structures. Brooten et al. (2012) found that the professional behaviour of the doctor carried more influence than the gender of the other health professionals in the quality of collaborative working relationships with other professions in the organization.

As noted in Chapter One, historically women were not admitted to universities. Although the first female physician in England was licensed before women were allowed to have university education in that country, she trained as a nurse and studied medicine on her own so that she was able to write the medical examinations (Baly, 1998). She was one of three out of seven to pass the tests. At the University of Saskatchewan, nursing education programming was a school in the College of Medicine until 1973 (Brown, Smith & Brown, 2009). Physiotherapy, an occupation that continues to be mostly female (Canadian Institute of Health Information, 2010), remains a school of this college although the entry to practice is now at the Masters' level (University of Saskatchewan College of Medicine 2011).

In an interprofessional environment the effects of structural interests cannot be ignored. Values and beliefs underlying and perpetuating those structures are of interest to the researcher exploring the development of interprofessional experiences. Financial constraints of any program dictates that there must be ample evidence that interprofessional education really does result in the development of knowledge, values and skills necessary for collaborative relationships

(Gilbert, 2005a).

Facilitators.

While the literature is concentrated on what needs to be fixed in order for interprofessional education to result in interprofessional collaboration in the workplace, there is some discussion of facilitating factors in the literature. Two of these structural devices were discussed in chapter one: the government policy enforcing collaboration in Britain, and the direction of Health Canada toward interprofessional education that is supported by research funding for projects in this area (Health Canada, 2007). The softer approach that Canada has taken generated several programs where organizations and faculty experimented with projects. These added to the pool of knowledge about interprofessional education strategies in the Canadian context (Health Canada).

Underpinning both the approaches to interprofessional collaboration was the assumption that interprofessional education would improve collaboration that would in turn result in improved health and health care. As discussed previously in Chapter I there was a substantial lack of factual evidence to support this logic model, but these government initiatives resulted in more research in this area. Other, less political, factors were influential in promoting both interprofessional education and collaboration. These were related to changes in the post-secondary education of students for the health profession, in the health care environment, and also contexts of the patients or clients.

Educational setting.

Hale (2003) saw the movement of all health professional education programs into the university setting as a facilitator for interprofessional education. If all programs were in one location ease of collaborative programming among the health profession educational

organizations would be enhanced. In addition to the convenience factor is the issue of similar levels of educational preparation. Lamb and Shraiky (2013) recommended attention to incorporating informal meeting places in addition to the formal learning environments possible only if they were largely co-located.

With the move of the health care professional education programs to the university came the requirement of graduate degrees for the teachers of these students. This structural requirement put the various health professional students on a more level field in the areas of theoretical and research preparation and common language. In some cases students from various professions may have taken the same courses. These commonalities may increase the respect for and understanding of each other's knowledge and skill levels.

Diversity and specialization.

The increase in amount and diversity of health knowledge and skills has resulted in greater specialization both within and among the health professions (Canadian Nurses Association & Canadian Medical Association, 2005; Hale, 2003). While much of the literature related to interprofessional education has been focused on the requirements for, and barriers to, interprofessional education and collaboration, Erickson, McHarney-Brown, Seeger, & Kaufman (1998) saw the increasing complexity of the health care milieu as a facilitating factor. Complexity demands the input of several areas of expertise. Not only is a greater knowledge base required for all health professions, but each professional is becoming more dependent on the work of others to meet the requirements for patient-centred-care because no one professional can be expected to have the knowledge and competence for all situations (Erickson, et al., 1998). The current growth in knowledge and technology requires health professionals to rely on the wisdom and skills of each other to get the work done (Gilbert, 2005a, Seymour, Cooper, Farley,

Feaster, Ross, Pellegrinni, & Sachdeva, 2013). The ongoing intensity of this change set the stage for collaboration and its complexity for the purposes of IPC and was effective for the participants in understanding each other's roles and expertise (Seymour et al., 2013).

Erickson et al. (1998) advocated for interprofessional education to be situated in community settings where the traditional barriers were less influential. However, complexity may continue to be a barrier for interprofessional education in community settings in the same way that it is for research and education in other areas (Bruner et al., 2011; Gilbert, 2005b; Zwarenstein et al., 2005a). The complexity of administrative structures related to programs, institutions, and professional bodies provide the majority of these barriers in all settings.

Length of stay.

Hospital lengths of stays have decreased over the past years (Canadian Institute of Health Information, 2013; Hale, 2003). This change means that each health professional has a shorter period of access to each patient necessitating trust in and reliance on each other's knowledge and skill. Duplication of effort by various professions each working in their own silos, in a 'multi professional' manner, during these short stays wastes valuable time and may result in less comprehensive and effective care. The system cannot afford inefficiencies. Communicating findings with team members and making collaborative decisions about the plan for care is of critical importance for effective, efficient care.

Consumerism.

The final facilitating factor discussed by Hale (2003) was that of the growing consumer movement in health care. Consumers have greater access to health and medical information through the media, including the internet (de Matteo & Reeves, 2013; Ford & Fettler, 2000;

Korner, Ehrhardt & Steger, 2013; Morath, 2003; & Schilling, 2002). This knowledge is expected to increase the patient's ability and desire to participate in health care decisions and evaluation of personal results (Chong, Aslani & Chen, 2013). Health Canada's framework guiding interprofessional education (Oandasan et al, 2005) stipulated that the patient should be an active participant in health care but did not specify how this would look. The patient as customer was expected to define what quality and value are for service (Ford & Fettler) and participate "at all stages of the treatment decision-making process, including information exchange, deliberation (discussing treatment options and consumer preferences) and arriving at an agreement on a decision to implement" (Chong et al., 2013). Hale implied that an important aspect of quality to the consumer was health professionals cooperating with each other rather than "protecting professional turf" (p.123). She stated that the growth of consumerism in health care has decreased the tolerance of this phenomenon by those receiving health care.

Changing roles of professionals and clients.

The patient is, according to Chong et al. (2013), Epp (1986) and Lalonde (1974), expected to be a partner in responsibility for his or her health, hence the emphasis on health promotion. If the consumer is given this responsibility then the health care professions must have the responsibility to work as partners with him or her. Oandasan et al. (2005) believed that best way to achieve optimum results for health was to put the patient at the centre of an interprofessional collaborative effort by health professionals. Overtly involving the patient as the central part of the health care team with responsibilities for his or her health was seen to be the way to achieve optimum results was to put the patient as an integral participant of the interprofessional health care team. This major shift in and of itself could change the way that many health care agencies and professionals go about their business. Patient-centred care has

been recommended by several researchers, for example, Bonifas and Gray, (2013), Chong et al. (2013), De Matteo and Reeves, (2013), Engel and Prentice, (2013) Legare et al. (2013).

Another projected change that may well affect roles and relationships among health care professionals and in collaboration, is that of skill and knowledge mix. In his final report for the Commission on the Future of Health Care in Canada, Roy Romanow stated:

> While much of the focus is on immediate and looming shortages of some health care providers, especially nurses, the deeper and more complex issues relate to their changing roles, the need to re-examine traditional scopes of practice, and the challenge of getting the right mix of skills from an integrated team of health care providers to deliver the comprehensive approaches to health care that Canadians expect (2002, p. 92).

According to Romanow (2010) following his report on Health Care in Canada, the problems with provision of quality health care in Canada were not just about money and numbers of health care professionals, but more significantly about how health care professionals worked together to deliver their products. He noted, using registered nurses and physicians as examples, that health professions were fine with expanding their scopes of practice but had difficulty accepting the expansion of practice of another profession into an area that they perceived as exclusively theirs.

Gittell (2000) found that overlaps in work roles actually improved quality of work because these shared areas required more communication. She carried out research in the area of relational coordination among staff who facilitated flight departures and in another project, among nurses on a surgical unit. Parameters of relational coordination that she measured were accurate, timely, and frequent communication, conflict resolution or problem solving, shared goals, shared knowledge, and mutual respect (Gittell et al., 2000), all aspects of collaboration. In

that study the authors found that these relational attributes were correlated with patient perception of a higher quality of care, more effective pain management, and decreased length of stay as well as role overlap.

Most of the above facilitators arose from the health care system. This foundation was consistent with the genesis of the perceived need for interprofessional collaboration leading to the interest in interprofessional education. Barriers and facilitators could be changed by the decisions made by those who have influence in the organizations concerning professional education and practice, including governments. As has been shown by the rapidly increasing numbers of papers being published related to interprofessional education, changes are also being generated by the people who teach, research, and practice in the health professions.

State of the Literature Related to the Area of Study

Within the literature it is clear that health care professional relationships are an important goal of IPE because they are key to collaboration. While the current state of the research literature touches on issues related to relationships such as professional socialization, identity, status, and gender there remains a lack of understanding as to how these relationships are formed, maintained and changed and how the students make sense of these dynamics in practice. The literature review, though thorough, was not clearly focused on the central research question. The summary of the literature did not seem to be organized around the main question of how these students might experience IPE at SWITCH. There was little about student run service learning organizations that are also interprofessional of which SWITCH is one of the pre-eminent Canadian examples.

CHAPTER III: METHODOLOGICAL APPROACH AND DESIGN

Interprofessional education caught the interest of governments and health profession educators internationally. The impetus for this attention was the belief that the collaborative practice relationships of health professionals not only enhanced care but saved lives and money. Unfortunately, while there is a significant body of literature linking interprofessional education to interprofessional collaboration, there was little known about the nature interprofessional relationships and experiences of students, although it can be seen in recent literature that knowledge is growing. One place to begin rectifying this lack in our understanding is to learn from students in interprofessional practice about their experiences and the sense they make of them. The exploration of this experience for students is the focus of this research.

Restatement of the Purpose

The purpose of this research was to gain understanding of the relationship experiences of health profession students in a context of interprofessional clinical practice. The questions that guided this study were:

1. What are the students' experiences in forming and working in interprofessional relationships?
2. What sense do the students make of these experiences and relationships?

These questions relate to developing understanding of working relationships in a specific context at a specific time. The findings will be in the realm of meaning and understanding rather than explanation or prediction (Mackey, 2005). For these reasons the methodology and methods used to address the questions are in the qualitative paradigm. Following is a discussion of the methodology and methods that were used to gain that understanding of student experience and meaning.

Phenomenological Methodology

There are many forms of qualitative research but the methodology that facilitates the investigation of questions related to lived experience and sense making is that of phenomenology (Van der Zalm & Bergum, 2000). In order to select the most appropriate form of phenomenology for this study it was important to have an understanding of the development of the conceptualizations of phenomenology. Lowes and Prowse stated that if one did not have a good understanding of the philosophical origins of the research methods used one ran the risk of methodological confusion which would threaten the rigour of the research (2001). Each phenomenological philosopher put his or her own perspective on the methodology resulting in several different approaches. For example, Streubert and Carpenter (1999) listed descriptive phenomenology, phenomenology of essences, phenomenology of appearances, constitutive phenomenology, reductive phenomenology, and interpretive phenomenology. Descriptive phenomenology is achieved through exploration of the richness of experiences. Phenomenology of essences involves identification of common essences and imaginative variation to determine the relationships among them. In pursing the phenomenology of appearances the researcher studies the various presentations of a phenomenon or object. Constitutive phenomenology is used to explore how phenomena exist in our consciousness from our first impressions to "a full picture" (Streubert & Carpenter, p.53). Reductive phenomenology is similar to transcendental phenomenology. Interpretive phenomenology involves describing the lived experience and interpreting the meaning of it (Mellor, Cottrell, & Moran, 2013).

Origins of phenomenology.

While Hegel is often associated with early phenomenology, it is Husserl who is credited for initiating the new science. Hegel's work was seen by Dermont Moran (2000) to be one of the

precursors to the phenomenological movement started by Edmund Husserl. Husserl's starting point picked up on the duality of mind and body where Descartes left off with the premise that Descartes did not achieve true objective thought (Fjelland & Gjengedal, 1994).

Husserl believed that by setting aside what we have learned we could determine the essence of a phenomenon. Moustakas stated that "the empirical phenomenological approach involves a return to experience in order to obtain comprehensive descriptions that provide the basis for a reflective structural analysis that portrays the essences of the experience" (1994, p. 13). For Husserl, knowledge came from experience (Mackey, 2005). Knowledge from experience obscured the objective knowledge of phenomena therefore what was known must be set aside to learn about the real phenomenon (Moustakas, 1994). The strategy for gaining knowledge, then, was an intuitive one because it was not based on previous learning (Moran, 2000; Moustakas, 1994).

Once the real essence of the phenomenon was found, Husserl employed *imaginative variation* to acquire the full sense of the phenomenon. Imaginative variation was imagining the phenomenon in different forms in order to perceive the whole entity. Husserl determined that because the phenomenological process included setting aside or bracketing out pre- learning, phenomenology was the most rigorous science. He labeled this bracketing epoché (Moustakas, 1994). Sokolowski (2000) explained pre-learning as perception having many layers that may be actual or potential. Husserl's focus was epistemological; he was concerned with the nature of knowledge (Leonard, 1994).

Heidegger and interpretive phenomenology.

Heidegger, a student of Husserl, was more interested in subjective 'being' than in objective knowledge. His was therefore, an ontological stance. For him, everyday being, which

he named Dasein (Draucker, 1999), was the focus. The rigour in this approach stemmed from acknowledging one's knowledge and assumptions related to the phenomenon or experience and the role that played in our understanding of the phenomenon.

Heidegger believed that knowledge was taken-for-granted. He saw knowledge as being subjected to influence by our environment for example, our language, culture, and history (Moustakas, 1994). The assumptions and perspectives that our language and culture are based in are not always retrievable in our consciousness: they form an unconsidered basis for our ways of knowing. Leonard expressed the situation as: "Thus although the self also constitutes her world, she is constrained in the possible ways she can constitute the world by her language, culture, and history, by her constitutive purposes and values." (1994, p. 47). We cannot fully set aside that which we do not know we know. In this sense then, when more than one person is exploring a phenomenon the knowledge resulting from this quest is co-created.

In an interpretive study that is based on Heidegger's approach to phenomenology attention to what he termed the *Fore-Structure* (Plager, 1994) of understanding is important. There are three parts to *Fore-Structure.* The first is the understanding of the phenomenon that we bring to the study. This is called *the Fore-Having*. One must have a perspective on a phenomenon to have an interest in learning more about it. This perspective is called the *Fore-Sight.* The understanding of appropriate questions and answers for this study are the *Fore-Conception* (Leonard, 1994). The *Fore-Structure* is what Husserl would attempt to set aside in order to study a phenomenon. In contrast, Heidegger would acknowledge it as contributing to the understanding of the phenomenon.

These two views about the roots and nature of knowledge and being have affected the approaches to the use of phenomenology to develop knowledge in disciplines other than

Philosophy. Husserl distinguished between objective knowledge (what the object really is) and subjective knowledge (what we perceive the object to be). In his quest for objective knowledge he focused on what knowledge 'is'. This orientation guides transcendental phenomenonology (Moustakas, 1994). Heidegger's ontological approach, built on by others such as Gadamer (2006) and Streubert & Carpenter, (1999) guides interpretive or hermeneutic phenomenology.

Study Methodology

I chose an interpretive phenomenological approach to explore the students' experiences of their interprofessional working relationships. There are two key factors determining the selection of a phenomenological approach. The first, and most influential is that the questions are ontological in nature rather than epistemological. The first question is purely descriptive in nature, dealing with the experience of the phenomenon. This question could be answered through Husserl's reductionist approach however that is not the intent of this research. The answer to the first question depicted the context which gave clues for understanding the answer to the second question. It was the second question, related to meaning making, which placed this study in the ontological realm and elicited discussion related to the meaning made out of the experience.

Interpretation through sense making was explicit in the second question. Because sense making and meaning are socially constructed (Anderson, 1991; Plager, 1994) the social context was key to the understanding this phenomenon. Plager stated:

> [Positivist] approaches remove the subjects from the context of the situation and attempt to characterize them by a set of objective properties. The meaning of the person's or family's life world, their lived experience, their situatedness, their concerns, and what matters to them are left out of the picture (p. 67).

In other words, studying a phenomenon out of its context does not result in an accurate understanding of it.

Another effect of this social construction is the part the researcher plays in the co-construction of knowledge about the phenomenon. I as researcher had *being-in-the-world* determined by my culture, language, and experience. Lowes and Prowse (2001) went so far as to note that their supervisor was also a part of the social world affecting their interpretations of their research projects. The effect of their supervisor's preconceptions was taken into account in their research as an acknowledgement of the significance of the process of social construction.

While I was aware of my positionality in relation to the research I proposed to do, I was not naïve enough to believe that I was consciously aware of everything that should be bracketed out in order to reach an objective understanding of the phenomenon. In addition, the participants in this study had the same challenge (Beech, 1999; Lowes & Prowse, 2001). This understanding of the nature and relationship of knowledge in our experience was the second factor in the choice of methodological approach.

The methods used to explore the questions must have coherence with an interpretive methodology. The methods related to selecting participants, data gathering, analysis, rigour, and ethics. The strategies to achieve these functions are discussed below.

Methods.

The phenomenological methodology chosen for this research was that of interpretive or hermeneutic phenomenology; throughout this dissertation it is referred to as interpretive phenomenology. Van Manen noted that hermeneutics are related to people, therefore hermeneutic phenomenology is specific to the study of people and meaning (1990). This method has the advantages that it provides for the influence of previous experience and learning throughout the process and facilitates exploration of current experience in interprofessional

relationships and the interpretation of meaning drawn from that experience. While the acknowledgement of the subjective world has been a determining factor in the selection of the methodology it is important to note that at all times respect for the voice of the informant was critical to the rigour of the research.

The distinction between methodology and method relates to the difference between the conceptualization of the approach, as a general direction and guide, and the details of putting it into action. The methodology in interpretive phenomenology in this study followed the guidelines initially set out by Heidegger and adapted by Patricia Benner (1994), while the action details, or methods were influenced by Benner, Tanner (2003), and other researchers as noted in the description of the details. The reason for choosing Benner's approach to interpretive phenomenology as the guide to the methods was that as a nurse she was a health care professional who also worked closely with Hubert Dreyfus, a philosopher particularly well versed in Heidegger's approach to phenomenology (Benner, 1984, 1994). My comfort level with Benner stemmed from the day that she spent with us as we were developing our outgoing curriculum and I also drew heavily on her work, From Novice to Expert: Excellence and power in clinical nursing practice (1984) in both the classroom and clinical teaching. Christine Tanner is also a prominent nurse researcher and educator who collaborated with Benner (Crist & Tanner, 2003). Both Benner and Tanner have used interpretive phenomenology effectively in their research in the area of nursing practice experience and expertise (Benner, 1994; Crist & Tanner).

Following is a description of the research methods that were guided by the methodology to uncover understandings related to the research question. The process of carrying out the methodology included methods related to informant selection, data collection, and analysis. Considerations related to rigour and ethics were examined throughout. Critical to the process of

this methodology was the understanding that none of the methods will occur in the absence of any of the others. For example, recruitment of informants was undertaken at the beginning of the study but also occurred throughout the data gathering and analysis phases as necessary due to the transient nature of volunteering in SWITCH. Rigour and ethics were maintained throughout. All of the above were influenced by the context.

Context of study.

The macro-context for this research consisted of the international move toward interprofessional collaboration and the belief that interprofessional education was one of the preferred strategies to achieve this goal. Part of this context was the role of Health Canada in encouraging and mentoring Canadian universities toward interprofessional education for students of the health professions (2007). The meso-context was the University system, specifically in this case, the Universities of Saskatchewan and Regina that embraced the ideal of interprofessional education. The student run Student Wellness Initiative Toward Community Health (SWITCH) program at Westside Clinic in Saskatoon provided the micro-context. These levels of context are interdependent. Health Canada provided the encouragement, incentive and funding for researching interprofessional education and for piloting interprofessional education projects, often through universities. The knowledge and experience gained from these initiatives was collected through the Health Canada Interprofessional Education for Collaborative Patient Centred Care program in the form of reports (2007). These projects assisted Health Canada to meet its goal of interprofessional collaboration.

Description of SWITCH.

SWITCH was a group of university students, mainly from the health professions, who provided client services at the Westside Community Clinic in Saskatoon since 2005

(Government of Saskatchewan, 2007). The vision of this student run program was "To maintain an operating, interdisciplinary student-run health clinic in conjunction with health professionals and community partners to serve clients in Saskatoon's core neighbourhoods" (Student Wellness Initiative toward Community Health, 2008). They accomplished their vision through providing health care, both clinical and health promotion, during extended hours at the Westside Community Clinic on Wednesday evenings and Saturday mornings. The students partnered with Community Health Services Association, Saskatoon Health Region - Primary Health Care, and the University of Saskatchewan. In 2007 they received national recognition (through the Tommy Dougls Celebration of Medicare Award) for their focus on prevention and wellness through collaborative practice.

While the initiative was not limited to health sciences students, the majority of the participants were from medicine, nursing, social work, physical therapy, dentistry, kinesiology, psychology, pharmacy, and nutrition. (Student Wellness Initiative toward Community Health, 2008). The program was overseen by a steering committee of students.

Interprofessional practice in SWITCH.

The students were organized to carry out the clinic work by a Shift Supervisor, who was a senior student in the initiative. There were three clinical teams and one social team, as well as an upper level psychology or social work student who was available as a *floater*. In addition to providing clinical care the students prepared and served snacks and coffee, talked with the clients in the waiting room, and played with the children. When SWITCH was in progress there were also a physician, nurse, cultural support worker, and receptionist and three to four mentors from various health professions present. The students and mentors worked voluntarily.

Selection of participants.

De Witt and Ploeg's (2006) only criterion for selecting participants for a phenomenological study was that they are "willing and able to articulate their experience of [the] phenomenon" (p. 223). The recruitment of participants for this study was then centred on asking for health profession student volunteers who, by definition, would be willing. This process was carried out in person, by the researcher. Students in nursing were not involved. An information sheet was available to provide information about the project for students to reflect on while making their decisions about becoming involved in the study.

There were no exclusion criteria for those who volunteered because by definition, the students working at this clinic qualified for the following additional criteria based on Morse's recommendations (1991) for good informants:

1. The key qualification was participation in the phenomenon of the interprofessional practice experience through SWITCH. This gave students the experience that this study focused on.
2. Willingness to participate in the research was a prerequisite to the decision of the participant to volunteer and sign the consent form.
3. Students of the health professions were taught early in their programs to give detailed information about patients and situations. This ability was also important for participation in the project.
4. Students of the health professions were also taught to critically examine situations and information. In this study, it was made clear that participants must be willing to use this ability in relation to their experiences in collaborative interprofessional practice.
5. Students in the university nursing program did not participate in this research because I either taught or would teach all of them, a situation which would require a higher level of ethical strategies. During the data collection I did not meet or recruit nursing students.

Data collection: Interviews.

The main form of data collection for this inquiry into the relationship experiences of health profession students in a context of interprofessional clinical practice consisted of interviews. Data were collected from late August to January. Given the nature of the study as an interpretive phenomenological one, based upon the experiences of its six participants, observation as a formal data collection technique was not warranted. I did, however, refer to several informal observations of the clinic (predominantly the waiting area) in my discussions of the context of the clinic. My use of interviews is elaborated further in the following paragraphs.

All interviews were conducted individually. Given the approach to this study as one based upon interpretive phenomenology, it elicited *individual* accounts from students concerning their experiences of interprofessional relationships in a clinical setting. The order in which interviews were conducted was as follows: *Gloria, Coffee, Sally, Karen, Ann, Sophia*. It should be noted that process for the reporting and treatment of data emerging from the interviews was an incremental one. That is, the process involved memoing and note-taking regarding emerging new perspectives for inquiry and additional topics requiring elaboration in subsequent interviews. These emerging perspectives pertained, for example, to participant experiences in an interprofessional clinical context, clarification of experiences of cognitive dissonance relating to SWITCH clientele, and to eliciting a deep and rich interpretation of context within which these participants worked and interacted. In short, the experiences and interpretations that emerged were based upon *individual interviews with each of the six participants, incrementally and sequentially conducted and collectively analyzed and portrayed* with a view to maintaining the integrity and uniqueness of the voices of individual participants in the overall reporting.

There were three major considerations for interviewing. One was that the technique was effective in gaining the information needed. It was important to remember that the purpose of the study was to provide an understanding of experience and the meaning that experience brought to the individuals. To achieve this goal, interviewing consisted of exploratory questions, which were largely open-ended to gain the richness necessary, probing questions to obtain the depth, and clarifying questions to determine that my understanding was correct. Sorrell noted: "Thus phenomenological interviews are not 'conducted' but rather they are participated in by both the interviewer and the respondent. Both … are empowered through awareness of new meanings in lived experiences" (1995, p. 1120).

The second consideration for the interview was the environment in which it takes place. The most obvious requirement was that it was in a place where participants felt comfortable, would not be interrupted, and could concentrate on the task at hand. Part of the ability to focus was dependent on the timing. The timing had to be such that both participants were not being distracted by a looming commitment to some other activity. It was my responsibility as researcher to be respectful of time for the volunteer participant as well as myself.

Another important part of preparation was building rapport to set an environment of safety and trust because of the personal nature of the discussions (Sorrell, 1995). Sorrell noted that this part of the relationship process may take a different amount of time with each participant and may involve learning who I am or finding shared experiences. The rapport was facilitated by the participants seeing me volunteering and coming to me with their interest in the research. This trust was important to the participants' authenticity and their comfort in critiquing my understanding of their experiences.

Accurate records of the interviews were also an important consideration if the research

was to have any value. In order to achieve accuracy the interviews were digitally recorded and transcribed. A further step to ensure accuracy was proof reading the transcripts which I did. It was important to understand going into the data collection process that while I, as researcher needed some control over the direction of the discussion, I also was changed as a result of it (Sorrell, 1995). One of the things that I love about teaching is the learning that I gain from the students. I anticipated that the interactions that I had with the other participants would be rich experiences for me. However, I also had to be committed to shaping the interview rather than the participant responses. As I read and reflected on the transcripts it was essential that I evaluated my interviewing based on its potential in, or actual leading of, the answer.

Guiding interview questions.

In qualitative research the researcher is the instrument used to collect the data (Sorrell, 1995). A set interview schedule would impair the authenticity of the data collection. Having said that, it is useful to have an opening question to gain information from which further questions will be generated. I thought that this question would be of the *grand tour* type (Spradley, 1979) "Tell me about your experience as a volunteer in interprofessional practice at SWITCH". When I read some of Heidegger`s work and realized the importance of the participants' *Fore-Structure*s and *Being-in-Time* I changed my first question to `Tell me about yourself` (See Appendix A for a list of guiding interview questions). Advice from researchers for further questioning in interpretive methodology follows (Crist & Tanner, 2003; Sorrell; Willis, 2004).

Interpretive questions ask *what* rather than *how*. Probing for deeper information was managed by questions such as "How did you feel?", "What else was happening?" "Tell me more", "What did you make of that?", "Tell me about [this experience] again." Other types of interview question took place with some of the participants, and were related to the relevance of

my ongoing interpretation of the data (Crist & Tanner, 2003). Willis (2004) stated that during the interview processes participants may become of aware of aspects of their experience that they had not thought of before. He explained that the enquiry "brings to view the subjective states and interpretations of people who have engaged in a common experience…which may have been overlooked or repressed by powerful interests" (p. 4). Willis saw this as an important contribution of interpretive research.

Modes of Involvement is an important concept in interpretive phenomenology. Plager recommended incorporating this into the research in order to clarify the researcher's involvement in the study and situate the participants in their everyday lives and interpretations (1994). The Mode of Involvement of the researcher determined the type of problems identified for the study and the methodology to be used. Heidegger identified three Modes related to modes of involvement (Plager, 1994), the first two of which are the focus of interpretive research:

Ready-to-Hand involvement occurs when everyday activity functions so smoothly that processes and equipment are not a part of conscious consideration.

Unready-to-Hand involves a breakdown in functioning that draws attention to processes and equipment. Plager stated that we must be aware that it may not be useful to read back from the breakdown to the smooth functioning. She used the example that studying an unhealthy family to learn about healthy family functioning may not result in accurate findings (1994).

Present-to-Hand does not involve smoothly running everyday activity but rather the person is challenged by a difference from usual activity or outcome to observe and reflect; regarding process and equipment as having discrete properties that can be studied separately or in relation to each other. It is in this mode that experimental research is done (Plager, 1994). In this study the questions related to the *Ready-to-Hand* Mode of Involvement in that the aim was

to understand everyday experience and the sense made of it. However, by asking questions that draw attention to it, the participant may be drawn into the *Unready-to-hand* Mode of confronting the process which leads to the *Present- to-Hand* Mode of contemplating processes that they had not focused on before.

Context as data.

Benner noted that the goal of interpretive phenomenology is to study the phenomena of meaning making and understanding of the experience of SWITCH in its own terms and these terms include the context that the phenomenon occurs in (Benner, 1994). I have a working knowledge of the meso-context and macro-context in which the participants worked from my own clinical practice in the core neighbourhoods. While I was superficially familiar with the physical and micro-social context of the organization and building that SWITCH occurred in, I did not have the whole picture, nor was I intimately aware of the social context in which SWITCH operated. I was invited by the coordinator to spend some time there when I was ready to ask for volunteers, which I did, both to familiarize myself with how it actually worked and to give the potential participants an opportunity to meet me as the first stage of establishing rapport.

In summary, during the interview process, I continually looked for new information, more depth and clarification of previous information, and feedback on my understanding. Once I had a preliminary analysis from the first four participants, I used the last two interviews to check my interpretation of the participants' experience. Through this process the interpretation became a co-created work, including similarities and differences in experience and meaning. It was critical to this form of research that data collection did not occur in isolation from the analysis. Analysis and interviews occurred concurrently to inform each other in that I had to think about the participant's answer to my question in order to determine where to go next with the

interview. Once I read the transcript I was able to find the meanings or interpretations of the participant's experience.

Data Analysis.

Qualitative research goes beyond the limits of the natural sciences to direct us towards not only "knowing that which is shared by persons in similar situations", but also "knowing that which is particular to the lived experience of an individual person" (Thorne, Kirkham, & MacDonald-Emes, 1997, p. 170). The researcher's interpretive description acknowledged the presence of knowledge of the participants at the outset the research process. Thorne et al., advised that this knowledge should be considered part of the *Fore-Structure* to the inquiry. The framework provided by this foundational knowledge would be challenged throughout the research process, but it provides a valuable basis from which to consider variation in the themes emerging from the data (Thorne et al.1997; Plager, 1994).

The goal of this study was to uncover the lived experience and meaning of being in interprofessional practice as students of health professions. Embedded within this goal was the imperative to portray the voices of the participants with respect and accuracy, while teasing out the commonalities and differences in their experience and sense-making (Crist & Tanner, 2003). Benner (1994) saw this type of research as "studying persons, events, and practices in their own terms is to understand the world, self, and other" (p. 99). The voices were not to be viewed objectively, but embodied with history, experience, knowledge, relationships and meaning. The processes of analysis were to be carefully considered and developed to meet the goal and the implied requirements related to portraying the participants' experience.

Process for analysis.

Van Manen (1990) stated that the first step in the process was to identify a phenomenon

in which one was very interested and very committed to discovering at more depth. This step was completed through the development of the questions and the continuing focus and energy put into answering them. He cautioned that the researcher must focus on lived experience rather than conceptualizations. This work was to be continued throughout the study through the mechanisms of being true to the participant voices through use of direct quotes from the participants and reflexions and reflections that uncovered my own experiences, knowledge, and biases. These interests guided the steps of the process. I developed the following process to address the study questions. The initial step has already been done, although the need for focus and commitment will be ongoing. There is another, taken-for-granted step, previously discussed, that of data collection, that provides fodder for analysis.

1. Read the transcripts to obtain global understanding (Benner, 1994; Draucker, (1999).
2. Read again to develop detailed interpretation. (Benner)
3. Identify questions that naturally arose from the analysis for the next interview.(Benner)
4. Repeat the above steps with the next participant. (Benner, Draucker)
5. Consider data from Step 4 in light of the interpretation of data from the first participant to determine further clarification of concepts. (Benner)
6. Identify possible themes (Benner & Draucker).
7. Repeat the above processes with additional participants, moving back and forth between texts. (Benner, Draucker)
8. From this step on the writing and rewriting process (Draucker; van Mannen, 1990) took place uncovering understanding and meaning; similarities and differences; and, themes and patterns that linked the themes.
9. Identify commonalities and differences (Benner)
10. Return to participants for input on my interpretation of the findings (Sale, 2008; Thorne et al. 1997)

This process reflected the hermeneutic circle.

Hermeneutic circle and writing.

Rapport and Wainwright, (2006, p. 235) explained the use of this circle in research as follows:

> In interpretive phenomenology, imagery of movement stands as a metaphor for the perpetual motion of the hermeneutic circle. It is a movement of circularity within the process of understanding, explanation and interpretation of phenomena that is continuous and multidirectional and leads to deeper understanding through the revisiting, reworking and juxtaposition of ideas. Understanding is grasped in stages and only through snatches of recognition.

The back and forth movement from participant answers to text to participant feedback to the interpretation by researcher writing and rewriting and so on, allowed the acquisition of new information from the participants to enrich the description of experience and meaning. This process contributes to the rigour of the study.

Rigour.

The guiding philosophies and methodologies of qualitative research differ from one research project to another so that *generic* standards and criteria for rigour are not appropriate for all (Cohen & Crabtree, 2008; Draucker, 1999; De Witt & Ploeg, 2006). Interpretive phenomenology is based on the understanding that "knowledge is never independent of interpretation" (Draucker, p. 361). Criteria that look for truth and freedom from bias were not useful to evaluate findings from this methodology, instead, openness to show how the biases affected the study and the interpretations is valued.

While at one time there were generic frameworks proposed for *trustworthiness* or *rigour* in qualitative research it is now thought that these aspects of research should be tailored to the

specific philosophical basis of the methodology being used (Cohen & Crabtree, 2008; de Witt & Ploeg, 2006; Sale, 2008). Cohen and Crabtree, as well as de Witt and Ploeg, preferred the term 'rigour' to 'trustworthiness' for interpretive phenomenology. De Witt and Ploeg stated that "philosophical inconsistencies between interpretive phenomenology and the criteria of credibility and confirmability demonstrate their inappropriateness as expressions of rigour for this research methodology" (p. 221). This inconsistency relates to the methodology's acceptance of multiple perspectives and co-construction of interpretation among the researcher and participants in an interpretive approach. For the purposes of this study, the term rigour related to the strategies used to ensure quality of the research.

Within the literature related to rigour in interpretive phenomenology there were various strategies recommended either to assess rigour or to provide it. In addition there were a variety of labels for several of the aspects. I devised a framework for this study that organized the strategies into four categories of rigour suggested by Kitto, Chesters, and Gribich (2008): theoretical, procedural, interpretive, and evaluative rigour. The strategies used within each of these categories will be discussed below.

Theoretical rigour.

Theoretical rigour refers to the "soundness of fit of the research question, aims, and the choice of methods appropriate to the research question" (Kitto et al., 2008, p. 244). The fit of the purpose of the research, research questions and the methodology has already been discussed. The criteria used in the selection of study participants that were based on capability and suitability related both to the research questions and the methodology. For example, the questions required that the participants had experience in interprofessional practice so that students in a student run interprofessional practice setting were selected as participants. The methodology required the

critical thinking and reflection: skills that were purposefully developed through the education programs that these students are in.

The methods were designed based on the underlying philosophy of the methodology as supported by the literature. In her review of published research that used Heideggerian interpretive phenomenology, Draucker (1999) found a controversy as to whether rigour requires adherence to Heideggerian concepts as a guide to the analysis. This was a major decision for me because I wondered if the use of these concepts biased the data and the analysis so as to distort it from the participants' understanding. However I came to understand that the concepts that Heidegger put forward clarified the context that the data arose from and that affected the meaning gained from it for both participants and researcher. Both the data collection and the analysis were guided by Heideggerian concepts such as *Fore-Structure, Modes of Involvement, and Temporality*.

To maintain theoretical consistency, questions were asked in such a way as to obtain information and reflexion on experience and sense making of the participants. My analysis employed the hermeneutic circle which involved writing, reflection, reflexion, clarification and rewriting until the essences of the experience and meaning were clarified (Crist & Tanner, 2003; Plager, 1994; van Manen, 1990). I offered them the opportunity to review their transcripts. The focus on the details of the words and grammar could detract from the deeper understanding of the meaning of their experiences. Cohen and Crabtree (2008), Sale (2008) and Thorne et al. (1997) raised a concern with the accuracy of recall of the specific expression of the participant's ideas and perspectives out of context.

Procedural rigour.

Procedural rigour is attained through transparency of the conduct of the research, including the decisions that are made along the way (Kitto et al. 2008). According to Drew, "Calaizzi (1978) stated that the first question a phenomenologist asks when planning a study is not how to proceed but why he or she is involved with the phenomenon" (1989, p. 431). This is an implication for rigour that is specific to the data collection and analysis. The answer to this question can be found in the sections on positionality and theoretical influences. In both of these phases of the research I was co-creator of the expression of lived experience of the phenomenon but as a researcher it was critical that my part in that creation was visible both to myself and those critiquing my work. My interpretations of the concepts and the participant responses to these were reflected on in my reflexions that also formed part of the data.

It is understood that qualitative methods can be emergent throughout the study (Hewitt, 2007). The proposal described the reasons behind the choice of methodology, methods, and strategies to begin the study. At the outset of the project it was difficult to predict where the input of the participants would take the study and it was important to follow their ideas wherever they led in relation to the research aims. This need to be flexible required openness about decision making. Therefore, the decision log and journaling that I kept served as an important part of the research documentation, some of which can be seen in later chapters. My interpretations of the concepts and the participant responses to these were reflected on in my reflexions that are also part of the data. Because of the process of the hermeneutic circle in the analysis, the various versions of my writing were kept electronically or on paper to form a record of the movement of my conceptualizations.

Interpretive rigour.

The requirement of interpretive rigour is that there is a full demonstration of the data. This would entail ensuring richness of the data as well as making transparent my contributions to the data and analysis. Cohen and Crabtree stated that a rich account must include:

> strong evidence for inferences and conclusions and then reporting the lived experiences of those observed and their perspectives on social reality, while recognizing that these could be multiple and complex and that the researcher is intertwined in the portrayal of this experience (2008, p. 334).

It was important to recognize that the voice of the participant was the focus. Respect for the voice of the individual student participant meant that I not only portrayed and reflected on the story of the student fully and carefully but that I reflected on and revealed my own story so far as it may have influenced my interaction with the participant or my interpretation of what the participant meant.

According to Charmaz (2006), richness in this study required a range and depth of perspectives on interprofessional practice, giving enough data for comparisons to be made and themes developed. Richness included in-depth interviews with sufficient participants to ensure that the data supported a full exploration of the experience and understanding of the participants individually and collectively. The interview questions in Appendix A were guided by the selected concepts of Heidegger, to maintain Theoretical Rigour but asked in such a way as to elicit rich data from the participants.

Another critical element, that of evidence of the effect of time both through the ongoing experience of the participant and on the data by the researcher, needed to be overt in the documentation (Todres & Wheeler, 2001). As a student in interprofessional practice each participant was in the process of *becoming* through experience in time. Questions were directed

toward eliciting descriptions of experience and understanding as it changed over time for the student.

Consideration of the effect of time on the data was met through overt consideration of the changes in my thinking across the times of data collection and analysis through my records of reflexions. This emphasis on the effect of time was consistent with the importance of temporality in Heideggerian methodology: the influence of past, present, and future as they all merge in Being – in - Time and interpretation of the experience (Mackey, 2005, Todres & Wheeler, 2001).

Coherence is another requirement for interpretive rigour. Leonard (1994) described Maddison's understanding of coherence as an analysis that presents the wholeness of the conceptualization which includes negatives and differences as well as commonalities. Benner recommended looking for these perspectives in the Heideggerian concepts of situation, embodiment, temporality, concerns and meanings (1994). The guiding questions served to uncover these aspects of the participants' experiences. The significance of situation was evident in whether the participant saw it as functioning smoothly, or breaking down. Benner described embodiment as the bodily responses to the experience. Temporality is related to the understanding of the past, experience of the present and projection into the future. Concerns involve the participants' meaningful orientation in the situation and that common meanings are taken for granted and cultural and thus determine what we notice and how we perceive it. Part of the method of analysis for this study was to include a discussion of all perspectives to form a unified view. Consideration of the full scope of perspectives of the participants should be evident in my reflexion.

Interpretive rigour is also heightened by the resolution of the issue that precipitated the study (Leonard, 1994). Satisfaction of this criterion was provided through the understanding

gained from the findings related to the meaning of the experience of students in interprofessional practice. While these findings were not comprehensive in the topic area I hoped that they would point toward ways of enhancing interprofessional practice based on the understanding gained. The possibilities derived from this understanding completed the requirements of this criterion.

Evaluative rigour.

Evaluative rigour is related to the ethics of the research which are discussed below. Kitto et al. (2008) stated that in addition to the study receiving ethics approval the researcher must ensure that the portrayal of the findings is accurate. This was accomplished through returning to the transcripts for clarification and affirmation of understanding and through the writing, rewriting and reflexive processes. Discussions with my supervisor about my interpretation also contributed to evaluative rigour. Thus evidence confirming rigour in this area was found in the ethics approval, the consistency of the analysis with the data, and in my reflexive writings.

Rigour is a critical element in the research design and process. It increases the usefulness of the findings for future research and application to practice. Attention to the details discussed above was carried out to ensure the quality and transferability of the findings.

Ethics.

Ethics are also considered as part of the quality of a research project (Cohen & Crabtree, 2008). Todres stated that part of the ethics of an embodied inquiry, such as interpretive phenomenological methodology, is the pursuit of "ways of knowing self and other that stay within the value of the irreducibility of persons to objects, things, or summaries" (2007, p. 182). The reflexivity included as part of this methodology was a strategy that promoted the ethical aspect of quality. The ethical strategies for this project are discussed below using the guide provided by the University of Saskatchewan Research Board (2004) and the Canadian Institutes

of Health Research, Natural Sciences and Engineering Research Council of Canada, and Social Sciences and Humanities Research Council of Canada Tri-Council Policy Statement (2010).

Level of risk involved.

According to the University of Saskatchewan Behavioural Research Board, the most basic principle of ethical research involving humans is that the research should not expose them to harm greater than everyday life, and specifically for students it should not be greater than what would be experienced in exams and psychological tests (University of Saskatchewan Behavioural Research Board, 2004). The research board defined minimal risk as:

> the risks of harm anticipated in the proposed research are not greater, considering probability and magnitude, than those ordinarily encountered in daily life or during the performance of routine physical or psychological examinations or tests. Risks of daily life mean those risks encountered in the daily lives of the subjects of the research, considering their actual life situations, as opposed to the daily life of "normal persons" or of "healthy volunteers" as the case may be." (2004, p. 4).

Some might think that this study poses risks to confidentiality, even though the participants were not identified by their real names and were required to consent to this to become part of the study. The consent included agreement that statements from the transcripts may be used to illustrate concepts from the findings (see Appendix B). The use of code names was a strategy used to ensure anonymity. The participants were aware of the risk before they agreed to participate.

The other consideration in risk related to the study was that I am a faculty member and I teach in a health profession of which its students could be potential participants in SWITCH. I came from a position of power over students as a professo,r which in turn puts them in a vulnerable position. As there were few students from nursing who participated in SWITCH (personal communication from The SWITCH coordinator, Carol Courtney, 3 April, 2009), I

avoided having potential students in my courses as participants for this study. Because this was a student run endeavour, the risk related to power in the study was minimized. I chose to invite the students to volunteer to participate in the research. I did not meet any nursing students at SWITCH so this was not an issue. In order to avoid the risk of deception I informed those who participated in the study that I was both a graduate student and a faculty member. This information posed a risk to the rigour of the study because it may have affected the information that they gave me. It may also have affected their decisions to participate. With these strategies and others discussed below in place, this study was at the level of minimal risk.

Conflict of interest.

Another ethical consideration was that of conflict of interest. As a faculty member who taught interprofessional collaboration as part of a course, and as a graduate student who was focused on interprofessional education I was biased both from previous professional practice and from the learning and thinking I have done in this area. In my early years as a nurse in a multiprofessional team some biases related to professional stereotypes carried over into my questions and reactions during the interviews and analysis. To expose these biases I used my reflexive journal before and after the interviews and during the interpretive phase to focus myself on nonjudgmental acceptance of what the participant offers me.

Free and informed consent.

Free consent was guaranteed in this study given that I did not solicit cooperation from the group of students that I could potentially be responsible for evaluating at some time in their program. Each potential participant was given a summary of the purpose of the study and what participation in it entails before he or she made the decision about participation. They had the right to withdraw from the study and their requests to have transcripts or portions of transcripts

removed from the data would have been complied with had I been asked. The guarantee of this right provided the freedom of choice necessary to meet this ethical requirement. It was particularly important in this study given my other role as a faculty member.

Tee and Lathlean (2004) stated that open, informed consent procedures contribute to autonomy. Informed consent helps the participant predict and understand what the research entails and what the expectations of his or her involvement would be. Informed consent (see appendix B) included a brief description of the purpose of the research methodology, highlighting the risks related to confidentiality and anonymity as well as the strategies to minimize these risks. As stated above, I did not deceive the students in relation to my identity or my intents. The potential participants were also made aware of the amount of time their involvement could take. The consent included having the interviews taped and transcribed. The students were also made aware of the potential benefits or harms as discussed below.

Respect for vulnerable persons.

Vulnerability relates to the ability to make autonomous decisions about participation in a research project (Tee & Lathlean, 2004). This study did not involve observation of the participants with clients, nor my interaction with clients, therefore the following discussion relates only to the students who participated in the research. While students working in a student directed practice without faculty supervision might not be considered vulnerable, I was a faculty member at the university that they were learning in. As such they may have perceived me as representing their educational institution and this may have made them feel more obliged to participate. Tee and Lathlean also pointed out that it was the researcher's responsibility to continually assess the state of vulnerability of the participant.

One aspect of vulnerability related to the risk of manipulation by the researcher.

Watchfulness on my part for unintended manipulation through carefully constructing questions and responses during the interview was one way that I reduced this risk. There were times that I started out to ask a leading question and changed it to be open ended. Had I not done so it would also have had an impact on the authenticity of the findings. Other strategies were to read the transcripts with attention focused for unintended direction of answers from the participant, and post-interview reflexion to reduce risk in future interactions. In going over the transcripts I found my transgression to be chatty at times. This was useful in that it helped to develop rapport however it also increased my input into the findings. While conducting this study I was a participant (informant) in the doctoral research for two other graduate students in different settings. One researcher simply asked the questions and the other 'discussed' what she wanted to know. I found that I was more successful as an interviewee when I was given more information by the second researcher who built upon my previous answers. In reflexion I can see the parallel with the participants in my study. There were a few times when the participant would ask if she had given me the answer that I needed. My answer was to reassure her that there were no right or wrong answers because I was interested in her experience and interpretation. I also asked for enlargement or more detail of the responses.

Emphasis on the right to withdraw from the study, or withdraw part of the interview from the data, was maintained as a measure for autonomy. Ramcharan and Cutcliffe stated that in addition to being mindful of the right to withdraw the researcher must ensure that consent is renewed throughout the process (2001). The consent to be part of this research was formalized by the signing of the consent form (Appendix A) before the interviews began. Interviews were set up at the convenience of the participant in respect for her autonomy and time commitments. Maintaining the autonomy of the participant is only one aspect of vulnerability. Minimizing

harm, to be discussed below, is another important step.

Hewitt (2007) extended the concept of harm in research to the researcher creating discomfort for the participant. While I usually find it easy to establish rapport in one-on-one situations with students, I did not take this skill for granted. I consciously attended to being overtly non-judgmental and accepting of their experiences and the meanings that they derived from them. This approach was particularly important because I taught in a health profession.

Another consideration related to vulnerability could have been confusion over my role. Hewitt (2007) stated that exploitation through role confusion may be a risk in qualitative research. Although she was referring to research involving patients and carried out by health professionals the possibility also existed in this study. To be ethical I let the students know that I am a professor in nursing as well as a graduate student in Educational Administration and clarified that this research was being carried out in my graduate student role. Richards found that revealing her status as a General Practitioner in her research interviews actually gave her better data and related this phenomenon to having better interview skills when she performed within her profession (Richards & Emslie, 2000). In my case knowledge of my dual roles may have caused some confusion in the minds of the participants about how to relate to me and what my expectations are for this study even though I had clarified my role. In order to minimize this effect I was clear that I wanted to know about their experiences with practicing in an interprofessional approach and that that was what the questions would relate to (Beech, 1999). I did not perceive any confusion in the participants throughout the study except for needing me to restate a question because she did not understand it clearly enough to answer.

Reviews of the transcripts and my findings by my supervisor and critical reflexion throughout the research process also provided the opportunity to identify potential and actual

incidents where role confusion and unintentional leading questions or information may have influenced the participant's offerings and my interpretations (Tee & Lathlean, 2004). The participants were given the information to facilitate contacting my supervisor and the University of Saskatchewan Research Ethics Office if they had concerns about the research or the ethics. Checking for clarification with the participant provided another opportunity to expand experience and meaning as well as reassurance that I stayed within my stated role.

One other ethical dilemma that is related to vulnerability and autonomy is that of the description of unethical behaviour by the participants. The people that the students work with in this setting are also vulnerable in relation to being associated with the inner city and also possibly the reasons that led them to live there, such as poverty, mental illness, or discrimination. Only one scenario related to an ethical situation came up in the interviews and anonymity was maintained in the discussion. It was not discussed as an ethical issue but rather as an incident that produced discomfort for the participant.

Respect for privacy and confidentiality.

Privacy and confidentiality were at risk in this study due to the small sample size, the contextual information divulged, and the use of quotes to illustrate the findings. While students spoke to me during the SWITCH shifts about volunteering for the study, I made a point of speaking with several of the volunteers and providing information sheets for anyone who showed an interest. Consent to use quotes was obtained through the initial informed consent and the participants were made aware before they formalized their consents that their request to remove any statements that they made during the interviews would be honoured. One related issue that I have experienced in the past is that when the tape recorder was turned off and my paper put away, the discussion continued. In this research only what was recorded was used, in addition to

the descriptions of relevant routines observed while I was volunteering during the shift.

The participants described the contexts in which the experiences and events occurred. Contextual information also included identification of some characteristics of the participants but they were aware that they had the choice of what they divulged during the interviews. Experiences in the clinic were described in such a way that the clients were not identifiable, nor were their health concerns divulged. Confidentiality and anonymity were maintained by the participants.

Respect for justice and inclusiveness.

Respect for justice and inclusiveness may seem to be contrary to respect for vulnerable persons in that it is important that even those who are perceived as vulnerable deserve the opportunity to participate in research. This principle led me to consider including rather than excluding students in nursing who may be seen as more vulnerable from the study as long as I was not evaluating them, for it would have been good to offer the option of having their perspectives included. Hewitt (2007) stated that the principle of justice may interfere with the principle related to privacy and confidentiality, and in the case of this research I as teacher was in the position to have confidential information about a student that I might teach in the future. It was my responsibility to protect the student from this possibility. In the end, there were no nursing students involved in the study, not even peripherally because there were no nursing student volunteers on any of the shifts that I was there.

Another important aspect of this principle is the representation of each voice in the analysis (Benner, 1994). This representation included communicating the essence of each participant's perspective respectfully. Kitto et al. (2008) also stipulated that both positive and negative aspects should be included. These strategies are also significant to the rigour of the

study for without the full spectrum of experience and meaning elicited from the participants, the study would have little significance to offer.

Balancing harm and benefit.

The principle of balancing harms and benefits translates into decreasing harm and increasing benefit (Panel on Research Ethics, 2008). For this study the most negative harm would be a breach of anonymity or confidentiality. Participants were warned before they signed their consents that anonymity may be fragile due to the nature of the methodology but that I will do all that I can to minimize this risk, including having the participant's input into what contextual and descriptive information he or she feels is important to withhold for this purpose. The participants were more likely than I to know what information about them is significant to those who may identify them.

Hewitt (2007) stated that qualitative research often extends into the private experiences and thoughts of the participants. This characteristic is true of this study and leads to another possible harm to the participant; that of feeling some discomfort as he or she reflects on personal experience in interprofessional practice in the process of answering the questions I ask. My personal experience with journaling as a course requirement was that it was one of feeling both vulnerability and humility at times and I expected that some participants may have had a similar experience during the interviews. My role in this aspect was to remain accepting and respectful of the information the participants shared with me. This approach included being non-judgmental and providing the opportunity for the participant to explore the reflexion as fully as she would like in order to come to some personal resolution. In these cases the resolution came in the form of learning. I was not doing this in the role of therapist, instead, only a listener, as she clarified her thoughts.

By the same token, the reflexion referred to above may be a benefit of the study. The participants may have understood from their reflexions that they were making valuable contributions to the work that SWITCH is doing. They might have learned more about interprofessional practice through their reflexions initiated by my questions. Sometimes the probing that I did to obtain rich descriptions and understandings led them to a deeper conceptualization of the issues they discussed. They also received a brief introduction to some of Heidegger's concepts and phenomenology. As described in an earlier chapter, one of the goals of professional education is the instillation of a desirable professional identity and one of the contributing factors for identity formation is the relevant perspectives of others in interactions. Thus, taking the opportunity offered by this study to consider one's experience of contributing to practice in an interprofessional setting would aid the development of the professional identity of each participant as well as understanding those of others with whom they will be working in the future.

Because the emphasis on interprofessional collaboration is recent there is an ethical imperative to disseminate the findings as fully and as soon as possible. The understanding brought about by the findings will hopefully influence both interprofessional education and collaborative practice within their work lives.

Dissemination of the research results.

Dissemination is an ethical issue from two perspectives, the first of which has been identified above. The findings of this study must be publically available as part of the evidence base on which practice is built. This availability requires publication in peer reviewed journals as well as conferences. As the researcher and a professor I also have an obligation to put into practice what I have learned from the study and to communicate this with my peers.

The second consideration of this issue is related to the informed consent of the participants. The information given to the potential participants in order to obtain an ethically acceptable consent included notice that the findings of this study will be published in journals and presented at conferences and other public venues. The participants were aware that the method of presenting findings of a qualitative study includes vignettes and quotes that will publically describe the experience and understanding of individual participants to represent various perspectives.

Summary of ethical considerations.

This study had minimal risk for those who participated in it. The greatest ethical risks stem from the methodology in relation to confidentiality and anonymity and my dual roles as faculty member and graduate student researcher. With the measures that I put in place the risks were not greater than what the participants would encounter in their everyday student lives. Free and informed consent was obtained consistently before the interviews started and was in alignment with the University of Saskatchewan Behavioural Research Board's guidelines (University of Saskatchewan Behavioural Research Board, 2004a). The prospective participants would have been informed about the use of quotes and how the threat to anonymity will be reduced should they have been above the minimal risk that they agreed to by signing the consent form. I did do reflexive journaling in the analysis phase and incorporated much of that into the findings to maintain respect for the participant and the participant's voice. Hopefully the participants benefited from this study due to the reflexion on their practice that the questions induced. In the future, when this study is published and has contributed to the body of knowledge in interprofessional education, they will have the advantage of working with new colleagues who have been prepared in their basic programs with a greater understanding of collaborative

practice.

Chapter Summary

The exploration of the experience of and meaning made from interprofessional practice is best achieved through a phenomenological approach. Because each person has his or her own understanding of this experience interpretive phenomenological methodology was chosen. Integral to this approach is the understanding that the knowledge and understanding are co-constructed by the researcher and participants. For this reason, I used my reflexion as data throughout the full extent of the research.

Data were gathered from volunteers who were participants in a student run interprofessional clinic, SWITCH, in the core neighbourhoods of Saskatoon. Data were collected through taped interviews with participants. The process of the hermeneutic circle guided the analysis and subsequent interviews. Respect for the voice of the participant was critical.

Because there was no generic method for rigour for qualitative research I devised my own framework for this study that involved strategies in four categories: *theoretical*, *procedural*, *interpretive*, and *evaluative* rigour. This approach utilized strategies such as reflexion, a decision log reflecting the fit of the methodology and methods to the aims and questions of the research, and a rich data collection that encompassed the full scope of participant perspectives. Adherence to ethics was also an important part of rigour. An important outcome of the research will be the uncovering of possibilities for application to practice and future research.

The ethical strategies were guided by the Tri-Council policy statement (Panel on Research Ethics, 2008) and the University of Saskatchewan Behavioural Research Ethics Board (2004a; 2004b; 2007). They focus on minimized risk; respect of autonomy, privacy and confidentiality; inclusiveness, and balance of harm and benefits. Consideration was given to free

and informed consent, the workplace role of the researcher in relationship to the participants in view of vulnerability and justice for these volunteers, and the issues that the methodology brought in the area of confidentiality and anonymity. In respect for the participation of the participants there is an imperative to disseminate the findings so that their efforts can inform future education and practice in interprofessional collaboration.

CHAPTER IV: FINDINGS

This chapter begins with a discussion of the context in which the participants worked as well as a brief introduction of the participants. The largest portion of the chapter is a presentation of the findings from the interviews. The words of the participants are block quotes, single-spaced. My contributions are in Bradley Hand and separated from the rest of the document by three asterisks above and three below. The interview questions were based on Heideggerian concepts of Thrownness, Clearings, Temporality, Modes of Involvement, Fore-Structure, and Horizon. These concepts are briefly described in the section immediately below following which, each is examined in the light of the participants' experiences. Implications based in the findings for Interprofessional Collaboration complete the chapter.

A Brief Review of the Heideggerian Concepts

The selection of the Heideggerian concepts was based on readings of other scholars' works, most of whom were associated with Patricia Benner (1994). My understanding of the concepts was enriched by reading works by Byrne, (1998); Draucker, (1999); Figal, (2009); Gadamer, (2006); Fjelland and Gjengedal (1994); Heidegger, (1972/2002); Heidegger, (2009); Heidegger, (2010); Leonard, (1994); Mackey, (2009); and, Plager, (1994). The criteria used for selection were that the questions based on the concepts would elicit rich information about the experience and meaning of interprofessional collaboration as well as deepening my understanding of the participants and the meanings that they derived from their interprofessional collaborative practice.

Thrownness.

Heidegger believed that we are born into a world that already has understandings and interpretations of life and being, passed on to us by the culture and language of our families and communities (Leonard, 1994). *Thrownness*, is influential in the way we interpret experiences and determine what is important and appropriate.

Clearings.

Clearings are areas in which we share common experiences, values and beliefs and may include education, location, and culture (Plager, 1994). *Clearings* may also involve *Fore-Structure*.

Temporality.

Temporality is the acknowledgement that we all have a past, present, and future that are contiguous, merging in to each other. Heidegger understood that by the time we encountered the present it was already the past and the future was already the present. Heidegger saw the three of these together making up the 'Now' (1972/2002).

Modes of involvement.

Modes of Involvement, (Benner, 1994, Leonard, 1994) also known as Modes of Engagement, are related to our intentionality in *Being*. I have chosen the word '*Involvement'* in order to avoid confusion with the concept of *Engagement* (Huynh, et al., 2012) that is discussed later in this chapter. There are three related Modes: *Ready-to-Hand; Unready-to-Hand; and, Present-to-Hand.* Our involvement in *Ready-to-Hand* is habitual without reflexion because things are running smoothly as usual. The *Unready-to-Hand* mode is triggered by a breakdown in the process that brings what we are doing to the forefront of our consciousness. The third mode, *Present-to-Hand* consists of reflexion and theorizing on the breakdown event (Leonard).

Fore-Structure.

The *Fore-Structure* is influenced by *Thrownness* and *Being-in-Time* as well as what we learn from our engagement in *Being.* Plager (1994) saw *Fore-Structure* as linking understanding with interpretation. *Fore-Structure* has three components: *Fore-Having, Fore-Sight,* and *Fore-Conception* (Plager, p.66). *Fore-Having* is what we take for granted, for example, our unquestioned assumptions. *Fore-Sight* is the perspective from which we consider a phenomenon and *Fore-Conception* is what we would consider as valid about the phenomenon: the "sense of what counts as a question and what would count as an answer" (Plager, p. 57).

Horizon.

There are two components of *Horizon*: space and time. As MacKey (2009) explained space related to the concept of *Horizon* is the significance of a specific something to the person at a given point in time. For example, if a person has not eaten for 6 hours it is likely that hunger will be in the foreground of his or her attention or horizon. After eating, hunger would likely be in the background. Time is significant depending on how near or far away in time an experience occurred.

Clearing: Context

SWITCH was a student run volunteer clinic in the core neighbourhoods of Saskatoon, at the time of this study, the largest city in Saskatchewan. The program extended the hours of a pre-existing primary care clinic, Westside Community Clinic. The clinic was a branch of the Saskatoon Community Clinic in an area with a high proportion of First Nations and low socio-economic status people. The Westside clinic was situated in the Pleasant Hill neighbourhood on Saskatoon's west side. A major determinant of health in this neighbourhood around the time of the research was the low income. The average income per family in Pleasant Hill was $28,655

(City of Saskatoon 2012a) in 2010 while the city average was estimated to be $71,623 in 2010 (City of Saskatoon 2012b).

Community clinic.

The community clinics employed a multiprofessional staff of physicians, nurses, physiotherapists, occupational therapists, and pharmacists. Integrative medicine was also a part of the work of the clinic through the work of one of the physicians who was specialized in this area (Saskatoon Community Clinic (2012). The Westside portion of the community clinic did not have an occupational therapist but did have nutrition and counseling services. SWITCH augmented the Westside Community Clinic through extending the hours that the clinic was open and adding programming such as men's nights, women's nights and children's activities as well as having an Aboriginal Elder available. This Elder was also present at the Westside Clinic's Children's clinic for culturally focus parenting advice (Saskatoon Community Clinic, 2011c).

The mission of the Community Clinics at the time of data collection included the following activities to foster excellence in co-operative primary health care:

- enhance health and well-being through leadership and excellence in people-centred primary health care.
- ensure access to the health services people need by creating effective and co-operative partnerships between members of the community, interdisciplinary health service providers, and other health promoting organizations.
- engage people in deciding about their care and in planning and evaluating community health services.
- advocate for publicly-funded health care and for the conditions that lead to optimal individual, community and population health.

The values of the Saskatoon Community Clinic encompassed member participation in decision making, including the people who used the services; health

needs met through a user-provider partnership, cooperative health care run by people of the community as ideal, team approach to health care, support of the clients in attaining and maintaining their ideals in health, social and political action to remove barriers to health, equal opportunity to achieve health and receive health services, and responsible use of funds in providing the services (2011b).

Mission statement of SWITCH.

> Members of SWITCH recognize the intrinsic value of all people and their right to high quality health care. As future health care professionals, we strive to understand the social determinants of health, the principles of primary health care and the importance of socially responsive health promotion. Our vision will be based on local priorities, as determined through extensive communication with community groups and health professionals. After establishing this foundation, we will create and maintain a student-driven, interdisciplinary health centre to provide integrated and timely services to Saskatoon's underserved populations. SWITCH will provide an invaluable and sustainable link between students, health care professionals, community based organizations, the university, and the community. Students will benefit by gaining practical experience in an interdisciplinary setting and through exposure to unique clinical circumstances. The community will have access to a holistic approach to primary health care delivery. Within this mutually beneficial environment, opportunities exist to diminish barriers to health care, improve community relations, and make Saskatoon a healthier place for all. (Student Wellness Initiative Toward Health, (2012).

The interprofessional practice that was run collaboratively by students at SWITCH was reflective of the above value statements. The aim was to improve the health of the community while broadening the education of students of the health professions and enhancing the relationship between the university and the Saskatoon community.

The mission statement reflected the World Health Organization Primary Health Care goals of:

> reducing exclusion and social disparities in health (universal coverage reforms); organizing health services around people's needs and expectations (service delivery reforms); -integrating health into all sectors (public policy reforms); pursuing collaborative models of policy dialogue (leadership reforms); and increasing stakeholder participation (World Health Organization, 1978).

This mission statement also reflected the criteria of the Primary Health Care Model (World Health Organization, 1978) as modified in the Canada Health Act (Government of Canada, 1984/2014). The criteria of the Canada Health Act: Public Administration, Comprehensiveness; Universality, Portability, and Accessibility, were informed by the WHO Primary Health Care Principles (1978) which for the purposes of this document were listed as: Public Participation, Intersectoral Collaboration, Appropriate Technology, Accessibility, and Health Promotion (Stamler & Yiu, 2012).

Public Participation included clients in decision making about the health needs and strategies for their community. Through the inclusion of the users in decision making, respect for diversity was also shown (Stamler & Yiu, 2012). From the information on the SWITCH website it was clear that the organization and its members were committed to respecting diversity. This was shown by the acceptance of everyone in the waiting room whether it was for a clinic visit, food, coffee, socialization, child care, or just a place to ‘be’.

In the SWTICH clinic clients made their own decisions about treatment once the clinical team ascertained that they had the requisite information and understanding. Those decisions were respected as shown by the acceptance and caring that was shown to a frequent needle exchange user who had other health issues the team believed needed to be addressed but which the client

set as a lower priority than the need for the drugs.

Intersectoral Co-operation included co-operation and support among the community organizations that partner with the program. The SWITCH website listed the University of Saskatchewan, Saskatoon Health Region, and Saskatoon Community Clinic as partners and had a longer list of sponsors. Related to the concept of co-operation was collaboration which was people working together toward the same goal (Hean & Dickinson, 2005). Decisions about the practice and what was offered when were made by the board consisting of students from a variety of professional programs and disciplines.

The structure for interprofessional collaboration.

Appropriate Technology required that the approaches to care were appropriate to the culture and socio-economic resources of the community and the individual. The work of SWITCH met diverse health needs such as socialization, nutrition, childcare, and diversion in programs such as the women's night. The approach to health included an emphasis on harm reduction, including partnering with community groups in a needle exchange program with access to addictions counselors. To meet all these needs it is important to have a group of professionals who together can assist with the diverse needs of patients. Study participants described the use of alternative or integrative medicine modalities to broaden the choices in treatment for the community. The inclusion of a cultural advisor to the SWITCH council and volunteers, who also played the role of Elder for the community members in the waiting room, assisted with the provision of culturally appropriate care. The cultural advisor also provided the opportunity for the volunteers to prepare themselves with a smudge before the clinic began. She chose a product for the smudge that would not eliminate any person from participation. The First Nations cultures have strict rules about who can partake of each type of material burned.

Accessibility meant that the people for whom the health services are intended could use them uninhibited by barriers such as cost, attitude and physical obstacles. The students, mentors, and staff were accepting of all who came through the doors whether they were using the clinical services or the opportunity to read the paper, eat, have coffee or socialize. In order to have the facility be seen as a safe place for all, neither violent nor disrespectful behaviour was tolerated. One barrier that was present was that if a billable treatment such as a prescription was required the client had to be covered by billable health insurance. This barrier was not within the influence of SWITCH or the community clinics.

Health Promotion was a way of providing health services that required the participation of the client whether it was with or by that person so that the person retained control of his or her health. The food offered in the clinic was nutritious as well as being acceptable to the clinic users. Clients were taught self-care as necessary. The needle exchange program was connected to health promotion as it showed recognition that the person had the right to reduce the effects of the substance abuse by avoiding diseases spread by unclean equipment and techniques.

At the time of data collection the clinics at SWITCH were offered twice weekly on Wednesday evenings and Saturday from 1030 – 1430. In addition they offered separate programs for women on Monday evenings. They tried programming for men but that was not well attended so was discontinued. Social interaction was an important part of what the students offered at SWITCH and these programs also provided opportunities for nonclinical students to participate in the work. Student volunteers on the Social Team welcomed and talked with people in the waiting room, prepared and provided nutrition and coffee, and designed and led the women's activities. They also kept statistics on select characteristics, such as age group and sex, of those who came into the waiting room.

There was a well-equipped child care room in which the students provided care so that the adults could see the clinical staff without worrying about their children. It was common for people to come to the clinic to meet others, eat, and even to drop their children off in the childcare area so that the children could play with others. The students maintained a non-judgmental approach to the use of clinic services.

The clinical team consisted of students of the health professions, a medical doctor and a nurse, and other professionals who mentored students in the health professions. Often there was a needle exchange van parked behind the building during SWITCH hours as well as addictions professionals working onsite. Criteria for participating as part of the SWITCH team varied with the profession involved.

Each clinic was preceded by a briefing session that began with a smudge ceremony facilitated by a First Nations Elder. Volunteers introduced themselves following this ceremony. There was a shift supervisor who led the briefing session at the beginning of each shift, alerted the students to “red flag” issues such as chest pain, which had to be reported immediately, made sure all the roles needed were filled by volunteers, and determined who the client needed to be seen by first from the clinical team. The shift supervisor was a student with experience volunteering at SWITCH and did not need to be a member of the clinical team. This position was a paid role.

The program also employed staff members. There was a coordinator for SWITCH who was a professional and was the consistent person for the organization because there could be a significant turnover of students over time. While I was collecting data the person in this position changed. There was also a volunteer coordinator who was involved in booking the students for each shift. In order to facilitate the nutrition part of the program SWITCH had a part time

nutrition coordinator who planned the meals, arranged for the shopping, oversaw the food preparation and cooked. This person also changed during my data collection phase. In the waiting room there was a receptionist who provided information, managed the records and maintained the rule of respect and non-violence in the clinic. In addition there was a paid Shift Supervisor position that was filled by students.

The clinical routine was that the client was interviewed by the shift supervisor to determine the priority needs for the type of health professionals and students appropriate for the client's identified needs. Clients could ask to have fewer people in the interview and examination but usually there were no more than two to five people that saw the client (**Coffee)**. The full clinical team discussed how this situation should be handled, coached by the mentors as necessary.

Once the examination was completed the clinical team discussed the findings, with the permission of the client. The mentors and clinicians were part of this clinical team discussion. The mentors and students then discussed the conclusions of the team and the intervention, if any was needed. I did not observe this process first hand but rather had it described to me on multiple occasions. When the client had been presented with the conclusions and had chosen intervention options the students and professionals who interacted with the client reported back to the clinical team. This briefing provided the full clinical team with the understanding of the complete process.

At the end of each shift there was a debriefing session led by the shift supervisor in which all the volunteers participated, including me. Each student volunteer briefly described a highlight of the shift or how the shift was for him or her. Then the clinical team briefly presented their experiences, being careful to maintain anonymity. If the client had given permission for more

disclosure of his or her case more detail would have been given to enhance the learning experience.

Participant backgrounds.

The backgrounds of the participants related to the Heideggerian concepts of *Thrownness* and *Clearings*. *Thrownness* acknowledged that people were born into existing communities of knowledge, understanding, values, and culture (Leonard 1994). *Clearings* were shared areas of knowledge, understanding, values, and culture that a person could be part of as a consequence of learning and life experience (Plager, 1994). Two of the participants, **Gloria** and **Karen**, were born in a different country and culture or as part of an immigrant family. One participant, **Coffee**, grew up in the area that SWITCH was located in. **Sally** came from a small town in Saskatchewan. **Sophia** was born into an upper middleclass family in an urban area consistent with the family's socio-economic status. **Anne** did not give any information about her origins other than to state that she came from a very different background from the clients who were seen at SWITCH. It can be seen that there was a wide difference in the environments that these participants were *thrown* into at birth and grew up in.

Heidegger's concept of *Clearing* was used in the context of this research as the common interests and understandings that the participants had. There were six participants in the research project in addition to my supervisor and me. All of the students were in University of Saskatchewan programs except for the two participants, **Coffee** and **Sally**, who were in the Social Work program, which is part of the University of Regina. **Gloria** and **Karen** were in Arts and Sciences with the objective of being accepted into the College of Medicine. **Sophia** was in her first year of medicine and **Anne** had just defended her dissertation and was now a Psychologist. All participants were volunteers at SWITCH. Four of the students were originally

from Saskatchewan, and one other stated she was born outside of Canada but had lived in Saskatoon for some years.

The first participant, **Gloria**, had to be re-interviewed because of technical issues with the initial interview. She graciously volunteered to be re-interviewed. I thought about how this would affect the findings after her exposure to the questions and having time to think about her answers but decided to document what I remembered and have her determine how it reflected what she had said, then continue the interview to enlarge upon or clarify responses from the first interview. **Gloria** only had one clarification to make from my script and that was to correct the name of the program that she volunteered at.

One *Clearing*, like-mindedness, was identified in the first interview and was reflected consistently in the comments of the other participants. The common characteristics consisted of a desire to help those seen as less fortunate together with common and compatible values and understandings about health and the way that health care should be engaged in, including harm reduction. Throughout the interviews it became clear that this *Clearing* developed with deepened understanding gained from working with the clients and the mentors.

Clearing: Why SWITCH?

Why the students were attracted to the concept of SWITCH and what kept them there once they started volunteering was important to the understanding of their experience with interprofessional collaboration. Why they stayed there shed light upon how the program fit their values and met their needs. There were several common themes related to this question: Career Decisions; Helping Others Less Fortunate; More Clinical Practice; Interprofessional Collaboration, and, Why They Stayed. Another component of this *Clearing* was why the community members keep attending SWITCH. This latter question was not posed as a part of the

interview except for the last participant. It was derived after the fact from the students' descriptions of the success of the clinic from the clients' perspectives. I asked **Sophia**, the last participant, the question because several of the other participants had volunteered the information and I wanted to have it reflected on and formalized. The *answers* related to the relevance of the practice to the community members and the effectiveness of this student run clinic's approach as understood by the participants.

One of Heidegger's concepts related to *Being and Time* is that of *Fore-Structure* which relates our understanding of a phenomenon to our interpretation of it (Leonard, 1994). *Fore-Structure* is comprised of three sub-concepts: *Fore-Having*, *Fore-Sight* and *Fore-Conception*. *Fore-Having* is what we already know or take for granted about a phenomenon. *Fore-Sight* is our orientation toward the phenomenon, for example, its importance, relevance or desirability. *Fore-Conception* describes what we see as valid to explore about the phenomenon for example, what questions should be asked about it and what answers would be satisfying. For this study, my attempts to gain an understanding of the experience and interpretation of interprofessional collaboration were guided by these three aspects.

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Where Heidegger's concepts are concerned I am very much a novice in understanding and application therefore my interpretation cannot help but be flawed ,for which I hope to be forgiven, because it is still useful for shedding light on the participants' experience and meaning making.

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For Heidegger *Fore-Sight* focused on our orientation to what we were doing (Leonard, 1994). To understand our interpretation of a phenomenon we must consider the experiences and learning that would affect that, or that result in the person being in that situation. The question

``What attracted you to SWITCH``? was asked in each interview to gain a partial understanding of the student`s orientation toward interprofessional practice. Most of the participants included their reasons for 'staying' in their answer to what attracted them. The relationship between *Fore-Having* or, as simply put by Leonard, the assumptions or taken-for-granted aspects of the phenomenon, and *Fore-Sight* could be seen in the connection between attraction and staying. *Fore-Conception* was loosely defined as our understanding: what counted as a question and what counted as an answer (Leonard). There were times when the participants struggled with the questions guided by *Fore-Conception* because the questions that were asked were based on my understanding of IPC and the community. What counted as significant for me may not have been considered questions that were important to the participants. Some of the participants asked for a more specific focus, or rewording of a question, to determine what answer I wanted suggesting that either my or their *Fore-Havings* were obscuring their understandings of what information I was asking for. It may also have been related to the participants' assumptions that there was a right answer although I repeatedly stated that there was not a wrong one. Their desire to give the right answer also demonstrated their engagement in the research project.

Attraction to SWITCH.

What attracted the participants to SWITCH would show the participants' *Fore-Having* and *Fore-Sight*. Some of the participants learned about the program in the classroom and had little previous experience with health care provision and this particular community. Others had enough relevant experience in life or the community to consider the work done through SWITCH as important and wanted to be part of it. There were several reasons for the participants` decisions to volunteer at SWITCH. These motivators ranged from a desire for extra clinical experience to the perceived need to volunteer to facilitate career goals. For some the

decision was more complex as will be seen in the discussion below.

SWITCH was seen by some as a worthy place to volunteer because of its service area in the Core Neighbourhoods, a part of the city in which people that lacked many of the determinants of health lived, couch-surfed, or spent their days if they were without resources. Others saw SWITCH as a place to advance their career preparation through more clinical practice and through the experience of working interprofessionally. For some the interprofessional collaboration was the drawing card because they believed that interprofessional collaboration was the best way to deliver care, especially for people who were not advantaged by having all the determinants of health at their disposal.

Career decisions.

Gloria, stated that they chose to volunteer at SWITCH as part of their preparation to gain entrance to the College of Medicine. **Karen** heard about SWITCH first in a class presentation and then talked with a friend who had volunteered there and encouraged her to join as well.

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> **Karen:** we both wanted to get into medicine and she thought that volunteering at SWITCH was much more worthwhile – much more, well not better but it's good and you learn a lot when you volunteer there.

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> In following up on this question my own fore-Having, the assumption that these participants believed they would have a better chance of being accepted into medicine if they had interprofessional collaborative experience in a health care setting on their résumés, led me to carry on the discussion without verifying it. Unfortunately I did not pick up on this until I was reflecting on the interviews later. I may have been correct but other reasons could also have been involved, such as the experience at SWITCH helping them decide if

Medicine really was the right profession for them.

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Neither student discussed the aspect of the volunteer work at SWITCH as being a contributing reason for being accepted into medicine but described the things that they had learned there about medical and interprofessional care with great enthusiasm. In the end **Karen** found that she had learned enough about health care and what she wanted from it that if she did not get into medicine she would be happy in a different health profession career.

Anne also heard about SWITCH in class from a professor:

> My first attraction was just learning about – like our professor mentioned about this orientation at SWITCH and I just asked more about what it was about and so I went to the orientation and then my first shift and just the philosophy of SWITCH just kept me there. So, the first attraction was – oh, it sounds like something neat to be a part of…

Anne was disappointed that not many students from her program took advantage of the opportunity to volunteer at SWITCH in spite of her vocal enthusiasm for it. The philosophy of SWITCH fit with her answer to the questions of how best to provide care for people. In her previous employment situations **Anne** had worked in a team in which each team member was specialized to provide a particular expertise contributing to the whole service. Her response to good care was effective team work:

> So yeah that was my first professional experience working together towards the same goal – like I said – I just repeated that. So then that's always been my – building from that, you know – being able to work as a team.

It was this *Fore-Conception* that was partly responsible for **Anne's** involvement in the interprofessional practice at SWITCH. In addition **Anne** really liked volunteer work and her answer to where she should do that was that it should be in a place where it was really needed.

She found the core neighbourhoods and SWITCH to be a good match for what she wanted.

Volunteering at SWITCH satisfied several values of the student volunteers. There was the perceived need of the clients stemming from inequities in the social determinants of health, accompanied by the desire to volunteer "where it was really needed". The study participants also wanted to be competent in their selected careers and thought that volunteer experience would be a way of promoting that state. The clinic and its staff and clients also provided examples of holistic health care provision based on a wide variety of approaches to health and wellness and was accepting of all people except those exhibiting violent behaviour.

Social justice.

Gloria, the other student who was looking at medicine for her career, was also interested in SWITCH because of her social justice values:

> Because there's many determinants of health – we had one of the people from SWITCH come in and talk to a group that I'm with at STM [Saint Thomas Moore College] and she had liked this really simple equation: "Education determines income and income determines health" so if you take that to be true then there's, then a population that maybe you might find in Erindale already has so many advantages over the community that SWITCH serves and those advantages aren't necessarily, aren't necessarily biomedical, they just contribute to their health so to better serve the health needs of people like SWITCH serves you'd have to look at other factors like income or education or the opportunities that people face so, that's why you'd need a social worker, a nutritionist, or a spiritual healer or those other professionals.

Gloria and **Karen** saw the social aspects of people's lives as being part of their health and as such would need to be addressed by a group of health professionals working in close proximity to each other. **Karen** was particularly interested in the social side of health care, not because of the social justice aspect but because she believed health was multifaceted and

holistic:

> And social aspect of SWITCH – I totally forgot, not just medical, it's a social - see that's what I'm interested in, like the social and medical, aspects of SWITCH so that really interests me and that's the reason why I'm doing a sociology degree.

Karen wanted to be a doctor and was impressed by the ability of her doctor to refer her to another type of health professional just down the hall, to have what she saw as the more social aspects of her health problems dealt with. This led her to value the interprofessional aspects of SWITCH.

Sophia heard about the program in her orientation to Arts and Sciences and also highlighted the differences between the core neighbourhood community and the family and community that she grew up in:

> I just fell in love with SWITCH from the moment I heard about it in my Arts and Science orientation actually. SWITCH because I think social responsibility and holistic health are just such a big part of what everybody should be thinking about and especially me as a future physician…

For **Sophia**, the social justice aspect was a responsibility rather than a desire to help those less fortunate. She was aware that her status would change when she became a physician and described what she would have to do to maintain a connection with the people who were less privileged:

> I think a lot of it is in your outlook and just keeping yourself honest. Keeping yourself sincere, genuine and honest and reminding yourself everyday who you are and why you went into the profession.

While **Sophia** was aware of the difference between her status and those of the people served by SWITCH she also had an understanding of how to handle that gap; by reminding herself that circumstances aside, we all have commonalities as human beings. The difference in

status "*What can we do to fix this?"* was juxtapositioned with the idea that the less privileged also had something to offer her in terms of learning: *"or start to learn from the people who we are disconnected from by all of these social barriers"*. This last part of the statement suggested that **Sophia** saw that both she and the community members had something to offer each other; that the relationship was not unidirectional, making them equals.

The social justice theme as part of the reason for volunteering at SWITCH was echoed by **Anne**:

> I really liked volunteering in any respect so somewhere that I feel that there's a need so I just saw that need at SWITCH. It just really helps that community – like the five core communities – have a place to go and a place to be and a place to belong.

The participants who touched on the social justice element wanted to volunteer somewhere that there was a real need to help those with fewer resources. **Gloria** had already been involved in volunteer work with an organization that assisted people with learning to live in a North American, English speaking society. **Karen** was interested in volunteering because she enjoyed interacting with people. **Sophia**, as a privileged citizen, felt a responsibility to share her talents to decrease the gap in health but knew that she could learn from the community members. **Anne** added the need of people who are homeless or on the brink of homelessness to have a place to go and to belong.

Perhaps this *Clearing* of social justice orientation was at the root of their decisions for the careers they chose. Somewhere they developed the sense that the reward of helping others worked both ways. The strong social justice aspect of the clinic was a major drawing card for volunteers and may have been the most significant drawing card for the volunteers.

More clinical practice.

Two of the participants also cited their need for more clinical experience than what they received in their health professional programs. **Coffee** thought that she did not get enough opportunity for counselling people to know that it was really what she wanted to do in Social Work. When she volunteered as a participant in this study she did so because of her interest in and focus on research. **Sally**, who was also a student in the Social Work program, stated: *"I don't think that with the practicums that you get enough experience."*

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The issue of clinical practice time seems to be ever present amongst nursing students who feel anxious about being prepared to "hit the floor running" when they graduate. The desire to finish in four years or less creates competition between theory necessary to base practice on and practice itself – an ongoing dilemma.

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For **Sally**, the issue with experience was in part, knowing how to work with people in other professions and clients from different backgrounds; the other part was more practice in her chosen profession. **Anne** brought a slightly different dimension to the need for more clinical practice opportunities; that of interprofessional practice which was important to her given the interrelated medical and socio-economic influences on health.

The clinic was seen by the volunteers as a way to get sufficient clinical practice in a health care environment that had experienced mentors. These volunteers demonstrated an ethic of competent and informed practice for the well-being of all clients. They also wanted to be part of an interprofessional workplace due to their values of health being holistic and competence in all facets of health care expected of them.

***Interprofessional practice*.**

There were two interrelated reasons for the perceived need for interprofessional collaboration that were expressed by the participants. One was the acknowledgement that there are multiple influences on health by socio-economic factors as described by the Determinants of Health model. According to the World Health Organization (WHO), (2011) health is the product of many situational and environmental factors that the person may not have much control over, such as genetics, and access to health care as well as those factors that they are able to modify, such as behaviour. The understanding of the effects on health by community, social, economic, and physical environments, such as poverty and poor housing; led the participants to believe that an interprofessional team was necessary to the holistic approach to health care.

> **Coffee**: And no one profession can do everything or understand everything because everyone wants something different in their education. So to me it feels, it makes me feel good to know that the client, well, not my client, but the clients are getting the best care and I think when I am in the working world, I want to continue, I hope that I will be able to continue learning and working as part of a team versus everybody being individualized.

The relevant question (*Fore-Sight)* for these volunteers was "how can we help these people improve their health". The relevant answer (*Fore-Conception*) was through interprofessional collaboration that involves the patient and community as part of the team.

The second reason for wanting to have interprofessional practice was very similar: some areas of health care have already developed this diversity of professions in response to the extensive scope of knowledge and skill needed to provide care for the multiple needs of the client. Learning about these professions and how they could work together effectively was seen as important to providing this service.

Anne:

> and just knowing that in this field that you're going to work with so many different people from different backgrounds that can be helpful to what you're trying to do…

As an Educational Psychologist **Anne** worked with resource teachers, speech language pathologists, and special education consultants and knew that a positive outcome for the student is dependent on the way that these professions work together. With the diversity in professions represented by the students at SWITCH and with contact with the professional Mentors in the program, this was seen as a good place to learn and practice interprofessionally.

While **Karen** was not qualified to be on the clinical team and therefore, not able to participate in the clinical services interprofessionally, she still was attracted by the interprofessional collaboration:

> …That kind of attracted me and the fact that it all relates to medicine, like, like I don't know, I just like the whole idea of, I don't know, different professions working together so there are, sometimes there's physical therapists. I've never volunteered at a place where there were so many different fields that come together.

Karen's enthusiasm for interprofessional, or at least, multiprofessional, practice remained consistent throughout her interview. She confessed that she was:

> Really biased toward nurses and doctors. Like I kind of, for me in my mind, people come to see nurses and doctors and then the doctors or nurses will refer them to the social worker, nutritionist…

When she was born, **Karen** was *thrown* into a society at war where the diversity of health professions found in the western world other than doctors and nurses, were much less common (WHO Eastern Mediterranean Office, 2006). This report focused on health human resources of doctors, nurses, and pharmacists. It only mentioned unspecified allied health professions in

addition to the previous three professions. It was not until the last three (out of 18) pages that nutrition and disability workers were specified. Given that Afghanistan has been largely preoccupied by wars for **Karen**'s whole life this was not surprising. In her interview she spoke at length about her visits to a hospital in her home community where only the nurses were brave enough to enter to provide care, and only then in disguise.

This bias (*Fore-Having)* toward nurses and doctors was consistent with the finding of Zwarenstein, Reeves, and Barr et al. (2005) that even though the health professionals involved in patient care were working together the doctor was seen as central to the team. Therefore, for the study it was perceived that true interprofessional collaboration was not occurring effectively in the hospital if the doctor was not involved.

Sophia's focus was beyond working together with health professions and gaining more medical knowledge and skills. She was interested in getting to know other people in general, believing that all enriched her experience:

> And I think SWITCH does a lot of good educational; really interesting things. It's a great opportunity to network with other students and network with people that I normally wouldn't get a chance to talk to in my day to day life walking around campus.

For **Sophia** the experience was more than just practice in her chosen health profession and understanding others, but also learning about diverse people and developing relationships with them. It also went further than learning about people as she stated previously: …*start to learn from the people who we are disconnected from by all of these social barriers.* For **Sophia** the answer to a meaningful life as well as health care practice was about connections.

Anne summed up the importance of knowledge in IPC up as follows:

> I feel it [IPC] is a more powerful way of working … because I feel my scope of

knowledge is limited…it works better for serving all the needs of the [clients]."

Anne understood that often she did not have all the knowledge and understanding necessary to provide the best outcome for the client. Even if she was in a position to take the lead with a client she believed she still needed the input of others to achieve a good result. She saw that practitioners from various areas were necessary for assessing and meeting the clients' needs holistically.

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From my own experience working within this community I understand how important it is to respect the experience, values, and knowledge of its people in order to gain the privilege of providing appropriate health care. This is my 'appropriate' answer to the 'necessary' question of how to provide, or collaborate in, effective health care in the core neighbourhoods.

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Many of the reasons that the participants had for starting to volunteer at SWITCH will be echoed in later sections of this dissertation. These factors were especially related to the success of the program and to the learning experiences of the students. The participants who volunteered to take part in this research were able to see the advantages in the roles they filled to both themselves and to the community members that SWITCH served from the beginning of their association with SWITCH. They also continued to see the opportunities for more contributions and learning on an ongoing basis.

Why the participants stayed.

Anne's reflection: "*You go to orientation, go to the first shift and I swear you want to always be there, you know"* expressed the feelings of most of the participants. There were three main reasons why the participants continued to volunteer at SWITCH: the *philosophy* resonated with their own values, *the learning* met their needs, and the clinic gave them opportunity to

practice something that they found they loved. As potential health care professionals they were oriented to providing care where it was most needed and in doing it in a way that would be most effective, interprofessionally, for the community members. Perceiving the success of the interprofessional practice for a community that overall was short of health resources showed them that interprofessional practice and holistic approaches are the answer to health care quality.

Only one of the participants no longer volunteered at SWITCH at the time of the interview and that was because she had successfully defended her dissertation and had a position in her chosen career path. This participant, **Anne**, did explore the reason that some students left SWITCH shortly after they started. These volunteers were mostly on the social team and **Anne's** perception was that they left because they did not feel that they were included in or contributing to the important work of the team.

The philosophy.

Anne was the participant who put into words the idea that the philosophy appealed to her:

> …and then some philosophy behind SWITCH and what it did form my learning – it kept me there.

The philosophical orientation that **Anne** specifically spoke to in her interview was that of providing service in the location and way that it was most needed. This idea was echoed by **Gloria.**

The commitment to holistic care was most often referred to as a shared value or what **Gloria** referred to as being "*like-minded*" particularly in the area of seeing health as a whole of body, mind, and socio-economic status which included harm reduction strategies. **Coffee** stated that a significant value underlying the approach to care provision at SWITCH was that there was no judgment of the clients and their lifestyles and practices:

> We don't judge. It's a very harm reduction kind of meet people where they are. Do what we can for them while we can. Acknowledge the fact that people are in situations sometimes for, I mean there are bigger, it's like a systems theory that people are in situations for reasons other than their own. I mean, it's just, it's just not being – I'm just going to say it – not being racist.

When asked about a breakdown in the team work at SWITCH **Coffee** gave an example of a team member who expressed a different value set that "*made everyone feel uncomfortable*". This event will be discussed more fully later in the chapter. **Coffee** also explained her understanding of why some volunteers did not come back:

> I think some of them (student volunteers) come because they want the experience and maybe they're not – they've never been exposed to kind of, the issues of poverty and addiction and abuse and stuff. And that comes after they've volunteered and I mean they start on the social team before you can even be clinical so they get kind of exposed and what the clientele is like and what our philosophy is and how we handle situations and just how we treat people and I *think* if people feel uncomfortable with that, they don't come back. So I think it kind of – people weed themselves out.

These two examples demonstrated the importance of the shared values to this clinical practice. The second example also explained at least part of the reason for "like-mindedness". The issues that **Coffee** described above came with value laden explanations of their origins.

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> I have learned this from my own clinical practice and teaching in these communities so can corroborate Coffee's perception. My first professional visit to "20th street" occurred midwinter in the evening. It was dark and I was more than mildly apprehensive about walking from my car into the building that the meeting I was asked to attend was held in. After attending the meeting with a group mainly comprised of people from the core neighbourhoods I was

> more comfortable with my safety and also with the fact that we shared many of the same values. After all, I grew up in poverty, like many of the people in the northern communities that I lived in – the difference being that my father was an educated professional who chose a profession for which he knew he would be poorly reimbursed financially. Poor people are not threatening, difference can be.

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The other reason discussed for volunteers not returning came from **Anne** who felt it was partly because they did not feel that they were part of the team or were contributing anything of value. These two participants had also been on the board for SWITCH where the attrition of volunteers was discussed so it is not surprising that **Coffee** and **Anne** were the ones who raised the concern about volunteers who did not return.

Karen found that volunteering at SWITCH was much better than she anticipated partly because it reflected her beliefs about health and illness. She stated:

> Is it just because he or she is like feeling sick and does not want to eat? You know, bulimic or whatever? Or is it just because she can't afford, you know…because that's how she can't afford it or maybe there are some problems going on at home. You know – that's what I'm interested in – a more holistic view of medicine as compared to just the biological side effect.

This perspective was consistent with the Determinants of Health (World Health Organization, 2011) concept and was echoed by several of the participants who all saw this view as necessitating interprofessional collaboration.

The experience.

Because they understood the complexity of health and the need for interprofessional practice the participants all found the experience they gained to be a prime reason for staying. **Coffee** expressed this as:

> Everybody is there for the sole purpose to work with, like its volunteer so everybody's there because they want to be there because they want to learn.

How they learned from the experience and what they valued from the learning will be discussed in a section dedicated to exploration of this topic: *Clearing*: Learning.

Something they loved.

So yeah, it's great – I love it! This description came from **Coffee** who also said that working at SWITCH was addicting. She stated that:

> It's giving me lots of experience that I couldn't have gotten anywhere else so I think it's preparing me better than I think the college has which is – it's given that place to put theory into practice and kind of test the waters before I'm actually out there so I'm not just thrown out into the world with my degree…there's nowhere where we can volunteer like that anywhere in Saskatoon and get that kind of like [experience].

Karen loved the variety of experiences that she could have in one shift.

> On a good day, it's good because you're not just stuck doing what you're doing, you know to get to change every so often…there was lots of volunteers and lots of people – way busy. And, I got to change my place. At first I was working in the kitchen – I really like that – and after that I came down and took attendance for a while and then somebody else came and took over for me and I was just sort of sitting there and talking to people and just socializing and then after that I went to the SHARP van so that day was so interesting to me because I got to do different things and I loved the SHARP van. It was great!

(SHARP is an acronym for Saskatoon HIV/AIDS Reduction Program).

Karen was so enthusiastic that even the very slow days had an advantage for her. She said that when it was quiet she had an opportunity to relax and to greet people as they came in. When she felt like she was not really doing anything she appreciated the opportunity to just sit. She also found that as she volunteered she realized that the role of doctor was not necessary to

give her the work that she found satisfying: she could obtain this reward working as any type of health care professional.

Sally also stated that she loved the experience she got at SWITCH: *Yeah, I love [the experience], I like, and working together with other students, like you can learn from each other.*

Sophia echoed the attraction of learning and building relationships:

> I think that's why a lot of people go into the health professions is because not only do they find the science or the discipline of it really interesting but that…I just, I think; I'm just addicted to getting to know people and getting to learn more and build relationships, you know.

Throughout her interview there was a theme of connectivity for her own growth, and also for more effective health care and maintenance.

Although they were not part of the clinical team**, Karen** and **Gloria** also valued the learning that they participated in with the other students and with the community members. **Karen** was fascinated by a story that one of the clients told her about her life while she was waiting for her time with the clinical team. Both **Karen** and **Gloria** found the debriefing sessions following the clinic interesting. These sessions involved both the clinical and the social teams with each volunteer presenting a highlight of the shift, once again presenting the opportunity to learn from each other.

Related to the diversity of experiences available was **Karen**'s perception of opportunity for advancement in the volunteer program which added to its attractiveness to her:

> You can even go upwards, you know, from Category A you can become Category B and at one time, you can be shift supervisor and stuff like that so that was good.

Category A was the beginner level for SWITCH student volunteers. Category B was for volunteers in their second year with SWITCH. Category C was for those who qualified for the

clinical team. The Shift supervisor was an officially paid position to be applied for. One did not need to be in a health profession program but did need experience volunteering for SWITCH. This opportunity for upward mobility was only referred to by **Karen** but all the others except **Gloria** had been on the board or were shift supervisors.

The participants continued going to SWITCH for similar reasons that attracted them to the clinic. Once they started at the clinic they loved it. They valued experience with their chosen career and the health care milieu that was supported by mentors. They felt comfortable working with the values and principles that were obviously guiding the practice. Practice was highly valued by all of the participants as they learned to put theory into their practice. The addictions component was a novelty for some of the participants and the contact and practice issue was role modeled by those working in the area so that the initial discomfort was lessened. They learned in real life situations and were able to align their perceptions more realistically in relation to the addiction lifestyle. In short, they were concerned about their preparation for their own practice when they graduated and the extra practice they craved to increase their skills and confidence was a drawing card for volunteering at SWITCH.

Why community members came to SWITCH.

The reasons that were given by the volunteers for the people of the community continuing to come to SWITCH were offered from the SWITCH volunteers that participated in this study. These insights were in large part unsolicited by me because I was interested in the students' experiences with interprofessional collaboration alone but the participants were focused on providing services to the community and therefore concerned about why community members made use of the clinic and why at times the attendance was low.

Holistic care.

A discussion of the reasons for attending the clinic was included here because some of the participants thought it was important enough to talk about and it also was reflective of the effectiveness of the students' approach to health care provision for the members of this community. The favourable response of the community to this orientation to health care affirmed the importance of their volunteer work as well as confirming the usefulness of the interprofessional practice approach. An example of this perceived value was **Anne**'s description of the developing significance of the counselling opportunity for the people who attend SWITCH:

> With the mental health piece when I do the counselling – when it first started, it wasn't very busy but it was always busy on the medical side. But now it's that they regularly get at least one to two people per shift for counselling so then it picked up.

Anne continued on to explain her understanding of why the counselling service was accessed more over time:

> Some will say that they actually feel more comfortable coming there rather than another place because it's interprofessional and because it's students – they feel like they get a more holistic care and feel more cared – no, not more cared for – more personalized service.

We don't judge.

Coffee's identification of the application of the value: *We don't judge* may also have had an effect on the increase in people coming for counselling and the continued attendance for SWITCH clinics and programs. **Sophia** concurred with this explanation of why community members returned to the clinic:

> I guess it's just treating – it's taking what I've learned from SWITCH and

> treating all people the same. And treating all people with acceptance and without judgment, and understanding that so much of our existence and what we do and why we do what we do is circumstantial.

These participants understood that they would not be successful in reducing the social and health disparities if they went about it in a patronizing way. **Sophia**'s understanding that her privileged status was not her doing drove her acceptance and lack of judgment of the clinic clients:

> And why clients keep coming back, I think it's because of – we're at least partially successful at actually doing, at what we're aiming to do in creating a holistic health care centre. In creating a safe open and helping environment for clients to come. Having clinical and programming services to offer clients that are things they need so I hope that we're doing a good job of meeting the needs of the community and I guess by the clients that keep coming back and the new clients that start coming – I guess we are.

When **Sophia** was describing the positive experience for students at SWITCH she identified an aspect that could also be a reason for the clients continuing to come to the clinic: *It's a pretty ideal situation just because there's no huge pressure to put through a bunch of clients. So you really can take the time with clients.* **Karen**'s excitement about having the health care specialist that she needed just down the hall from her doctor was consistent with the emphasis on meeting the needs of the clients.

The students' assumptions (*Fore-Having*) were that health was influenced by several factors therefore health care needed to include multiple parameters in a holistic and interprofessional environment (*Fore-Sight*). They believed that clinics such as SWITCH were the way to provide effective care to those who had a deficit in resources especially *(Fore-Conception*). The students believed that the holistic and accepting approach may have been the

reason that the clinic was so popular. In addition the fact that time was taken with each client to determine the issues and to deal with them may have increased the satisfaction with the care for the clients. The routine of students and a mentor seeing the patient, then going back to the larger group to discuss the findings and options for treatment may also have reassured the clients that their conditions were taken seriously and decisions were well thought out.

Clearing: Learning

While learning was found to be an important reason for continuing to volunteer at SWITCH, the significance of this was much greater. Learning was highly valued as could be seen from the facial expressions and voice tones as the participants described the learning situations. Sometimes it was unexpected and caused the student volunteer to seriously reflect on the event (P*resent-to-Hand*). Other times it was "paradigm shifting" (Sophia) as for **Sally** experiencing the dissonance (Makowski & Epstein, 2012) that occurred when faced with the different value set of a client who was a drug user. **Sally** was coached through this by her mentor and learned that people must be approached from where they are at, not where she is at, in order to develop trust and keep the door open for further contact. Hodges (2009) stated that: "Mentorship relies on a supportive system where the mentor challenges the mentee to embrace opportunities and problems and realize (sic) their strengths and weaknesses" (p. 35). **Sally's** mentor supported her to work her way through the dissonance she perceived in this incident.

The participants learned from the mentors, the community members, and each other. They learned about themselves, practice, different life styles, and histories, and about interprofessional collaboration. They reflected on the learning and why it was successful and some worried why there were times when few came to the clinic.

Learning from each other.

The two students who were not in health profession programs were enthusiastic about their learning. Being in the clinic was meaningful to them because they could see the work of health care professionals in context and hear some of the discussion of clinical experiences during the shift debriefings. This helped them to clarify their desires to become doctors. When I asked **Gloria** what she had learned about working together at SWITCH she answered:

> Just how valuable it is and how necessary it is and how, - how, maybe feasible it is – it's not necessarily something very difficult to do. How it's really possible to bring together different professionals and have them collaborate to provide health care for people.

For **Gloria**, collaboration was a natural fit with the influence of the apparent deficits in determinants of health for the people of this community. She perceived it as being easy to do. Given the shared values discussed by the participants it may not have required a conscious effort to work together.

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SWITCH was set up to facilitate Interprofessional collaboration for the student volunteers. This is a critical difference from the health care system that has been steeped in a multiprofessional tradition. Changing to IPC in the current system will require multiple changes in professional socialization and traditional ways of interacting, both formal and informal. The volunteers at SWITCH who know how effectively IPC works will be useful ambassadors to move the change along.

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Gloria also described how people facilitated each other's learning experiences:

> So, at the beginning (of shift) they assign tasks so they ask who wants to work in the kitchen, who will do childcare, and childcare's usually one that people might

> hesitate to take to do because it gets kind of rowdy and boisterous and the needle switch is something that is really popular or it's interesting to see how, with some of the less popular tasks somebody will just put up their hand anyway even though you know it's not something they want to do so there's that sense, I don't know, sacrifice, or, or giving up of self because…just to get the job done cause you know it's important. So that's something that I see a lot.

Gloria used the specific example of the 'Needle Switch' [Needle Exchange] because this was an activity that was novel and many volunteers were very interested in learning more about it. The needle exchange is a harm reduction program in which intravenous (IV) drug users can bring in their used needles and receive sterile ones for their next injection. The needle exchange was a plum practice area according to **Gloria**, but the volunteers were willing to take turns in sharing the learning experience.

When asked what was so attractive about this experience **Gloria** explained that it was something that students did not usually get an opportunity to participate in.

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> From my experience with nursing students in the core neighbourhoods, all the students know that IV drug use occurs but many have not witnessed it or encountered much related to this life style so there is an exotic element to their interest. In the past spring an encounter with the SHARP program produced the most profound learning experience I have seen in any group of students I have had. Students *know* that there is IV drug use in this neighbourhood and most understand that it is a health challenge but have not met the human beings that practice it. The SHARP outreach worker, herself a former addict and sex trade worker, stated "Nobody wakes up in the morning and says "I think I will be a drug addict" or "I think I will be a sex trade worker" – "they are experiencing so much pain in their lives…" This statement was so different from what they expected, but put in such a plausible way that they were taken aback. Once

> again, the dissonance between IV drug users as deliberately unhealthy, and the drug user as wounded person caught them off balance and created better learning than I could provide with all the statistics, sociology and psychology that was available.

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Coffee described a situation where a medical student learned from her during a client interview:

> I let the med student do all, you know, do his thing because that was the main focus while she was there but then there were some things that she [the client] said that I wanted to just kind of delve, kind of, you know, ask her again to kind of repeat and ask that again and it went off into a totally different direction which was beneficial for, I think, everybody in the room and then afterwards the med student was like, "I didn't even think of asking that and I didn't notice she said that, I was so focused on the initial problem she came in with."

In this example the medical student learned from **Coffee** to be attentive to health issues that were not obviously related to the health problem that the client identified. Coombs found the boundaries of practice for the medical profession to have an effect on the interactions between physicians and nurses in the intensive care unit (ICU). She found that the additional knowledge about the patient status apart from what the monitors and lines could provide was not valued by the doctors. Here the medical student had focused on the physical and physiological assessment so was taken by surprise by the relevance of the information that **Coffee** elicited from the client.

The debriefing session was set up to optimize the learning experiences through reflection on the experience and sharing what happened with the rest of the clinical team. **Coffee** discussed learning from each other in the clinical debriefing session:

> During clinical when we're actually in our clinical room with just students we do debrief them because we're all just the clinical staff so we all have the

> confidentiality so it stays in the room and we can talk about somebody we just seen in detail – because that's how we learn.

The ability to learn from each other in the clinical debriefing is greater than the end of the shift debriefing because all the volunteers are present for the latter, and the issue of confidentiality is felt to be different when non-clinical people who are less immersed in the privacy culture are present in the room. **Coffee** ended this discussion by saying that while clinical details cannot be discussed in the shift debriefing, they still can talk about some of the things they did or learned so that the social team members share in the knowledge. She noted that although the social team members may not have the same understanding of confidentiality they do not ask questions that would indicate they wanted more detailed information than adherence to confidentiality would permit. **Karen** wished they could hear more:

> Not always are you allowed to discuss what happened. And I think they ask the patient, right? Not always do we get to hear the interesting, the meaty stuff but the social side of it or the medical side of it but we get to hear that sometimes. I think, no, I don't remember any one instance that they discussed the thing in detail. I don't want, I don't really know but still it's good to hear.

Coffee spoke about other students learning from her when she described some details of a health issue that was her major focus area: *There was some students saying "what do I do when somebody presents that to me?"*

Karen attested to the learning from others in the debriefing sessions as well when she was explaining how she got information about SWITCH:

> She [her friend] didn't really tell me about how people get together – at the meetings? And then right after the whole four hours you meet at the end to discuss what happened that day and you learn so many things, you know?

Because of **Karen**'s enthusiasm for medicine as her career, the discussions related to

medical issues and treatment, however brief, were of great interest and increased her desire to learn more.

The participants' learning from each other was given the same emphasis as learning from mentors. When a student was the source of learning she felt affirmed by sharing knowledge that other students did not have, yet valued. They also found learning from and about each other important, both for their own practices and providing more complete care for the clients. They were also willing to give up a valued experience for one of less interest for another volunteer to have the opportunity.

Learning from clients and community.

Sophia believed that it was her responsibility as a health care professional to learn from the people that she was serving:

> There's just so many barriers to health that people cannot control. And I think it's our job from the privileged side to go and say "okay, well what can we do to fix this – or start to fix this – or start to learn from the people who we are disconnected from by all of these social barriers?"

For some of the participants the living conditions and lifestyles of the clients and the community were foreign. At first **Sally** was uneasy about being in the area of the city that SWITCH is located in:

> I think like the first few weeks I went I was scared of sitting there because I'm, like I don't know what to say I don't understand, you know? And even though I had learned about it through social work and I experienced poverty in other countries, I had never experienced poverty in Saskatoon. Just in even going to 20th Street like I still, you know you have to be careful but lots of things that I was scared to do on 20th Street, I'm not scared to do anymore and you know... Precautions that I would take there are precautions that I would take in my own neighbourhood on the east side. Just safety! So yes, when I first moved to

> Saskatoon, people told me lock your door when you're driving down 20th Street and I'm like ... What I do on 20th Street is what I would do in my neighbourhood at 10 o'clock at night. You know, I still walk to Lorne – it's about the lifestyle and the culture but I feel that SWITCH is opening the door and providing the atmosphere for me to learn and otherwise how would you learn it? You have to get involved if you want be exposed to that…
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> ***
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> As a nursing student in my first clinical I was afraid to go into the room to meet my first patient: What would I say to her? Anxiety about what to say to people who are different than oneself is also common in my clinical students. As nurses we develop skills to communicate with clients within our own settings but going out of that range can make us uncomfortable, for example: how do "I from a middle class family and with great job prospects talk to a person who is homeless, an illicit drug user, sex trade worker, gang member, or obviously poverty stricken with less education? "
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Coming from a small town **Sally** had not been exposed to this lifestyle before and automatically started making an intervention plan based on the values that she knew. What counted as a proper life to her was to have a home as shelter to go to at night. She was not naïve about poverty or different lifestyles as she had travelled extensively to areas of the world where poverty was prevalent, but only as a visitor. She was caught off guard by finding this situation in her own province unexpectedly and needed her mentor's assistance to work through it. The contrast between what she knew and what this client lived was so great that it produced a profound transformative moment for her. **Sally** found that day-to-day life included many complexities for those who were impoverished and that what individuals perceived as the most basic needs could be quite different from what she thought was the norm. She reflected on her

value that housing was a basic need for everyone and with the desire to help this client appropriately and the assistance of her mentor she came to a fuller understanding of the meaning of different value systems.

Anne, who was completing her PhD when she volunteered at SWITCH, also described learning about living with poverty:

> I come from a very different background and some people – like the people I guess that take in SWITCH and so I've never really understood kind of the different backgrounds of people and how it affects their lives and choices they make and so I think that really opened my eyes to a whole new world that I didn't realize really existed and that can inform counseling because I mean I think it's people that come from different backgrounds that I've experienced that would come for counseling. And so just learning about it in school doesn't give you that whole other view so that practical experience, different world views.

Both **Anne** and **Sally** came up against something that they knew existed but did not understand the full implications of. Both participants had past experience working with people with illness and disability but while at SWITCH they gained a deeper understanding of what it is to be disabled or sick and deal with lack of resources at the same time. Both learned that different life circumstances affected the needs and decisions that people make.

Karen found she was very interested in the stories that people might tell about themselves. On the night I met her, her task on the social team was to sit in the waiting room and record the attendance statistics. This process included the age group, gender, and Aboriginal status (or not) of each person who came into the waiting room. She was sitting beside a woman who had been telling me her life story and when I left she continued to tell it to **Karen**. **Karen** was an avid listener:

> I've seen so many movies from the World War II time – not time but set in that

time – but I just was just kind of hearing of the stories in Germany at that time. Where were you? What did you do? So it was really interesting to learn stuff first hand and know that's not fiction, you know? Made by a Hollywood movie – it was the real thing.

Karen would be at least third generation post World War II and this conversation drove home that the war happened with real people and it influenced their lives significantly. I was also in the waiting room, waiting for students to volunteer as participants so I had the advantage of being part of the conversation at times and an observer at others. Her intense interest and attentiveness encouraged the woman to tell her more about herself which resulted in a significant learning experience related to her conception of health and her desire to become a doctor:

She asked me what do you want to do and I'm like somewhere in the medical field, you know? You know anything in the medical field I just love this thing. You know the whole idea of health and stuff. And she said "Yeah, and the first thing you need to do – listen to people" and she told me, I'm like "Why, what happened?" and she told me that she had a mole on her hand and she kept telling it to her doctor like three years or was it two years and she kept telling her doctor that this is cancer and he would be like "no, no, no, it's all right, it's nothing" and finally he realized because it was getting bigger so finally the doctor was like "Yeah, you're right" and she was like "Yeah, I've been telling you that for the last three years!"

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Given her inexperience in interviewing I was amazed at her skill in eliciting more information from the client. The difference may be that she was deeply interested in the woman's story whereas, I was very focused on the method of getting the 'data' that I needed for this research project. I was very interested in the participants' stories but felt that I must keep them on track. I confess that I gave Karen a lot of leeway to tell her story before I focused her on my task again. This privilege was related to my interest on how her story would relate

> to the topic on hand for me – students' experience with interprofessional practice. Eventually I realized that what she was doing was illustrating the need for interprofessional collaboration by telling a story about the lack of it.

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Karen learned from the story that the SWITCH client told that when the patient described a problem it was important to listen and respond to the patient's perspective in a way that was meaningful to the patient.

Much of the participants' learning from the clients was related to an understanding of what it was like to live in poverty in this community and how that affected the choices that they made. In many of the experiences it was the dissonance between what they knew as correct (*Fore-Having*) and what the clients lived that made this learning more significant. As long as everything was in line with their values and experience the learning went smoothly. When there was a situation that contradicted what they were used to they went from a *Ready-to-Hand* mode of involvement to the *Unready –to–Hand* mode.

The dissonance caused the participants to reflect, as in the *Present-to-Hand* mode, and come to a new understanding of why the clients' decisions were not always what students in the health professions, or people from a higher socioeconomic status would make. They also learned about the resources and complex challenges for people who live in lower socioeconomic circumstances and how to be more effective in assisting them with their health issues.

The myriad of issues affecting health for the people who used SWITCH created an effective environment for learning about interprofessional collaboration in health care practice.

Learning from mentors.

SWITCH had volunteer health professionals who acted as mentors to the SWITCH participants. They were resource people and teachers for the students of the health professions

but the social team participants also learned from them at times:

> **Sophia**:
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> Well we sometimes have a mentor on the clinical team and so like I said, the doctor/nurse practitioner and the social worker are the two mentors that are always there and then the other mentors kind of flux. There's a couple of other mentor's slots that can be filled by members from a variety of professions so only sometimes do we have the complimentary alternative therapies but they can see clients and just in terms of like the clients' energy and looking at things from a different and holistic perspective, I think they can definitely help.

During the clinical team discussion for each client, mentors played a role of guiding the volunteers in both their practice and their professional approach. An example of this was **Sally**'s interaction with her mentor in relation to the man who came in for the Needle Exchange described earlier. She gained a more realistic understanding of acceptance of the clients as they are. She also learned how important it was to 'keep the door open' for the client to feel safe in coming for other issues or for assistance if he or she decided to stop using the drugs. Even the negative experience with a mentor helped them learn. This was the mentor who expressed racist views and was asked to leave. The learning here was how important it is to have everyone subscribe to the critical values like believing that characteristics like darker skin, different cultures, and poverty do not define the person as less worthy. During the clinical meetings the volunteers on the clinical team received the benefit of all the mentors' wisdom and knowledge. Another person who played a role as a mentor was the First Nations woman who did the smudges at the beginning of each shift. After completing that ritual at the beginning of the shift she mentored parents in the culturally appropriate care of their infants and children.

Epiphanies and eye openers

Some of the learning that happened for these participants gave such a flash of insight, or

shift in understanding that it profoundly influenced their practice approaches. These experiences could be considered paradigm shifts as they resulted in rethinking what was important to them as a career.

> And like I said before, those eye opening experiences turn into a paradigm shift and how a person views other people they encounter. Things they might not have encountered ordinarily in a completely different way.

Sophia saw the eye opening experiences as precursors to a paradigm shift. Again, the difference and dissonance from the experiences and assumptions that the participants encountered led to profound learning, especially in the areas of lifestyle, career paths, and alternative medicine.

Different lifestyles.

Anne has been cited earlier in relation to having her eyes opened about the experiences that people of the community had and the circumstances they lived in. She then understood why they made the decisions that they did. She saw it as gaining a different world view that she could apply in her counselling profession.

Anne's 'aha' experience was similar to that of **Sally** when **Sally** was confronted by the differences between her life values and those of the man who preferred to spend his money on drugs. **Sally** learned from this situation and her mentor that health care professionals must not force their values or beliefs on clients if they really want to be effective in working with the person toward better health.

Different career paths.

On my first evening shift at SWITCH I met **Coffee** who stated that she was really interested in research and that would be what she would focus on in her social work career. She already had plans to go into graduate studies. After she had experience with counselling at SWITCH she learned that not only was she good at it but that she really enjoyed it.

> Wasn't sure what I really, where I really wanted to go because I was really interested in research so for my practicum, I did a research project and then just counseling at SWITCH – it changed my mind for what I wanted to do in my major practicum. Yeah, it just gave me that ability to kind of explore what I wanted to do. If I was going to be good at it and if I actually liked it with a commitment of a...
>
> Karen – Yeah, that's good. Now you're committed to it?
>
> **Coffee** – Yeah I'm kind of addicted to it – been there all summer.

While this might not be as significant as a paradigm shift, it did lead her to seriously consider a different direction for her career. Her special interest was women who had been or were being abused. With this focus she could combine counseling and research in her career.

Karen also realized that working with clients in health care was what she really enjoyed so that she would consider a career in any health care profession as well as medicine. She enjoyed listening to people's stories. She was excited by the learning from other volunteers' experiences in the clinic and she loved the interprofessional approach.

Sally learned that it would be better for her to not follow her plan to return to work in her home community immediately.

> I'm going to be graduating and I always thought I wanted to work in my home town and I came to Saskatoon just thinking I'm just going there to go to university and then when I have my degree I'm going to go back and now I'm. .. I fear going back right away because I feel like I need to gain some experience and just be an actual social worker outside of my own community first and then who knows maybe in the future we'll go back but I'll go back having some experience instead of just being green right away. And knowing what I can expect and what my professional role – like I know what my professional role is but experiencing that role...
>
> This statement came from my comment that when working in the core neighbourhoods

one gets to know the people well. **Sally**'s response was that she found this aspect challenging. She extrapolated this experience to her idea of returning home to work and realized that it would be best if she gained experience in her field and developed her professional identity before she provided services for people who had known her and whose value systems and knowing she had been *thrown* into at birth.

Alternative health care.

Sophia had been exposed to alternative health care modalities in a course in her first year of medicine. A doctor involved in the course was a role model who spoke about his change in perception of non-conventional interventions:

> Some doctors are more open to it than others but one doctor said that he had, you know, just the paradigm shifting experience where he saw acupuncture actually work for one of his patients that he just couldn't figure out and that he just couldn't help and then he finally said, okay – I guess this stuff works.
>
> **Karen** – I don't know how or why – but it works.
>
> **Sophia** – But it does so, So yeah sometimes it is as such – you could call it paradigm shifting experience that really shapes what the person is willing to expose themselves too and their patients to later on in practice.

Sophia's concept of a paradigm shifting experience was one that induced a person to change his or her default conceptualization about something resulting in a change in practice or values. This physician showed that it was possible to accept something that could not yet be understood or proven through the scientific method.

While the participants approached learning deliberately the most profound learning experiences were provoked by dissonance with their values, beliefs and knowledge. Their mentors guided them through the integration of the experience into their values and understanding. Mentors were an important part of teaching and learning. Not only did they

provide assistance with the details of practice and problem solving, but they were also part of the socialization process. Their exemplary practice and coaching encouraged the students to think outside their usual perspectives to provide holistic and inclusive health care.

Clearing: Like-Mindedness

In the very first interview **Gloria** coined the term "like-mindedness" in relation to the work relations at SWITCH. This *Clearing* was based on similarities and compatibility of the volunteers' *Fore-Structures.* A client centred, holistic approach provided common ground for the team to start from. Values related to holistic practice and a safe place to belong were expressed, most of which have been discussed earlier. **Gloria** had no experience with working interprofessionally or on teams so I asked her to think about working in a group on a class project. She compared this kind of group activity with volunteering at SWITCH:

> **Gloria:**
> I feel like at SWITCH it's easier…mainly cause there isn't marks involved…maybe it's because I already assume that there's like-minded people and that's why they're at SWITCH whereas I guess in the class project you might get a variety of different people who differ on, I guess fundamental views with you although that might also be the case with interprofessional. With SWITCH you are working on a team constantly.

Gloria found it much easier to work with others at SWITCH because they all had the same goals and values such as providing effective, holistic health care and a safe place to belong for the people of the community. She was the first person to allude to client centred care:

> I think another cool thing about the difference between SWITCH and the group project for school is that it's not really about the volunteers because they're all there to do something that's greater than themselves so I mean your personal preferences, or your bad mood that day can't really factor in very much to what you're doing because it'll interfere with the reason why we, you're there.

In this statement **Gloria** took the concept of having the same goal further to state that the value of the work that they were doing was more important than their own personal needs. They were doing this to provide services to people who did not have as many resources as the wealthier people in the city. This sentiment was indicative of the value that the other participants placed on working in this neighbourhood with its people. This value was that of social justice, a reason for volunteering with SWITCH discussed earlier. The goal of leveling the social determinants of health was thought to be so important that each participant had put aside her personal needs for recognition.

Like-mindedness was not only about values but about client-centred practice. Values related to holistic practice, acceptance, respect, and not judging were expressed, most of which has been discussed earlier. In the very first interview **Gloria** spoke about like-mindedness. **Gloria** had no experience with working interprofessionally or on teams so I asked her to think about working in a group on a class project. She compared this kind of group activity with volunteering at SWITCH:

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Client centred care.

Coffee described clinical interviews and the respect that they showed each other and the client: *Kind of not forgetting who's actually the important person in the room.* **Coffee** meant that none of the clinical team would try to excel by pushing his or her own values or beliefs on others in the clinical practice. The well-being of the client came before the status aspirations of the volunteer, thus emphasizing that the clients' needs were paramount.

Throughout the interviews there were many statements and descriptions of patient centredness. An example was when **Coffee** was assessing a client with a medical student and respected that the patient had presented a medical issue by putting that first. **Coffee** had been chosen to be there due to the likelihood of social concerns being contributory.

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At first I was a bit dismayed to hear that Coffee deferred to the medical student

> right from the beginning of the assessment because from my own experience in the area I knew how much social issues are connected to the health of the people and I thought that the social components may get lost. After thinking about it in terms of Coffee's reasoning I understood her wisdom: that it was important for the client to have her stated problem honoured by dealing with it first. This attention would be critical to developing trust. On reflexion I believe that this reaction on my part was due to me expecting that clinical relationships had not changed since I last worked in the hospital setting in 1998.

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Holistic approach.

As earlier described by the participants, health was believed to be multi-factorial so that care provided had to be holistic in order to be effective. **Karen** thought that the volunteers had a common value of health care being holistic in nature:

> **Katherine** - Yeah, the other volunteers – how does that fit with their ideas of?
>
> **Karen** – I think most of them come here the same, you know, I think most of them are interested in the social side of medicine too because if they wanted to at SWITCH because at SWITCH is more like the holistic approach to, you know, a person's wellbeing so I think most of them are interested in that, I think.

Coffee also affirmed her belief in the need to see health as holistic:

> Well I guess my understanding of interdisciplinary collaboration would be that not…peoples' issues aren't one sided and we, you have to take a holistic view when you look at health, when you look at mental health, spiritual health, emotional health and if you don't address all of those issues, you really can't address one of them.

Coffee later explained that she developed her belief that health issues needed to be handled holistically over time:

> I think just growing up where I did and what I learned is very much the medicine wheel. Very much the physical and spiritual and it's, uh, so that is something that's part of my values so going to social work, it was very much looking at all aspects of the person too. So, I think interdisciplinary – like that's what SWITCH just fits so well, I think.

Coffee drew the link between a holistic perspective of health and an interprofessional approach to health care services as did the others.

Karen explained why she thought health care should be holistic through the following example:

> When a person comes to a doctor, like there is not just a medical, not always, there are times when the patient feels some social stuff that, for example, if the patient is not eating well, you need to find out why. Is it just because he or she is like feeling sick and does not want to eat? You know, bulimic or whatever? Or is just because she can't afford, you know, So that's just one thing that comes to my mind. Because that's how, she can't afford it or maybe there are some problems going on at home, you know – that's what I'm interested in - a more holistic view of medicine as compared to just the biological side effect.

This case is an example that would fit **Coffee**'s idea of the need for a holistic approach to health care. **Karen** saw the connection between somatic health and mental illness or socioeconomic issues.

> **Sophia** thought that these two ideals were important to all SWITCH volunteers: SWITCH because I think social responsibility and holistic health are just such a big part of what everybody should be thinking about and especially me as a future physician.

The value placed on holistic health at SWITCH was lived out by the opportunity to have mentors who use non-conventional health treatments such as Reiki and having to have a social worker present at every clinic in addition to a doctor or nurse practitioner.

That like-mindedness was critical was shown by **Coffee**'s example of the smooth running of the clinic breaking down:

> …when we had a mentor whose values and philosophies didn't jive with SWITCH at all and it just kind of cemented the fact that everybody at SWITCH does have the same philosophy and values because everybody in that room was uncomfortable so it wasn't, yeah, so definitely it kind of brought back the fact that SWITCH is maybe unique or does share or the people that come in do share certain values and ethics and have to have them to be there. Or else it's just not a good fit.

The similar values and goals in this *Clearing* were important factors in the attraction to SWITCH and continuation of volunteering at the clinic. As **Coffee** described, when someone had differing values the situation became very uncomfortable. **Gloria**'s evaluation of working together on a class project as being more difficult than working at SWITCH with its like-mindedness was an example of how important shared values and goals are as a *Clearing* for Interprofessional Collaboration

Clearing: Interprofessional Collaboration

The student volunteers at SWITCH and their mentors chose to set the clinic up as an interprofessional collaborative practice. While those who participated in the original development may have assumed that interprofessional collaboration would provide effective services for the community members, some of the participants asked for clarification of the concept, which I gave.

> **Sophia**:
>
> I'm still, I think confused on the boundary between multidisciplinary and interprofessional and interdisciplinary. I'm still confused on those boundaries but I think the main thing I took home is just the team and how we can all fill in each other's gap and we can support each other. And we all bring our own

perspectives and our own knowledge together to treat the whole patient: the whole patient who is physical, mental, spiritual, and emotional and have their life circumstances and their life history.

At this point I clarified my understanding of the terminology for **Sophia** because it was important that she understand what I was asking.

Katherine:

The literature, to me, still seems to be confused about those definitions too. I have my own way of differentiating them but then so does everybody else. And I went to an interprofessional conference here in this city about three – maybe three years ago and the definitions that they were using were almost the opposite to the ones that I use. So when I talk about interprofessional, I'm talking about different professions working together as a team like SWITCH does where you know each other's roles and you respect each other and each other's roles – sort of as you were saying and the profession is the applied part of the knowledge and the theory. Whereas the discipline is the knowledge creation and research type stuff – the theory and knowledge bit. So that's my definition.

Sophia: That makes sense.

While there was confusion among the participants about the terminology related to interprofessional collaboration, there was no confusion about how it should be operationalized.

Past experience.

Some of the participants had past experience with working in teams, and two had taken a course delivered in an interprofessional format. Others had seen examples in health care delivery that led them to think that health care should have a multifaceted, holistic approach. Some had no experience at all. **Karen** had no experience with interprofessional practice but she was impressed with going to see her doctor about something and having the doctor send her to another type of health care professional whose office was just down the hall. **Gloria** also had no

previous experience with Interprofessional Collaboration and could only imagine what it would be like to work on a team.

Experience with teams.

The background in teamwork varied among the volunteers from no experience to **Sally** who had worked as office staff with a multiprofessional team and from that experience understood how interprofessional collaboration would improve care:

> The doctor would request a Saskapole or something to be put into the client's home. Telling the client, get this put into your home and this will help you be safe and be able to bath easier or whatnot. But the client doesn't have the financial resources to buy the type of equipment so they just disregard it, thinking, whatever, I don't have the money and I'll be careful, you know.
>
> Meanwhile the client falls – could be left in the home for a day while, before any one realizes this and then they go back into the hospital and the doctor says, well I told him to get, you know, so it's just like, I don't know how but there needs to be a team of people working with one client and if they all can just communicate with - like the physician could have said or had enough time to tell occupational therapy that this client needs this, then if they don't have enough money then maybe that's when another professional needs to look at, you know, is there any funding or you know, cause this client needs this thing because now it's costing the government money to have the client in the hospital and the client's health is at risk again and so I know that that physicians usually don't have time to communicate everything but yeah it could work as a team. I think that in the long run, you could save money, increase health and…

In this description **Sally** demonstrated her knowledge of the health care system that she gained from working at Home Care. She saw the gaps in communication within this team and the problems these caused for clients' health management. She could imagine how a client could have a health problem go untreated due to lack of communication of doctors and other health

professionals. She could also see safety issues occurring due to lack of communication and believed that collaboration would avoid these issues.

Experience with multiprofessional teams.

Anne had worked in multiprofessional settings with teams. When I asked about interprofessional experience she gave me examples of these teams but when we discussed interprofessional collaboration in depth she clarified that these experiences were not interprofessional collaboration:

> The one I was talking about was my first interprofessional. But before that I don't know if I had a sense of; I had a sense of team work but I don't think I had a sense of intercollaboration. I don't think it really entered my thought process, really so I'm not really sure if I had an idea of what that looked like before I actually was in it? And I had never really learned about it in classes or in programs. It was actually when I went to a conference for SWITCH earlier this year that I really… Well actually it first was SWITCH where they really talked about it a lot and then there was conferences here too. So I guess just my first interprofessional experience where I was exposed to it so I didn't have a sense before that but when I had that first job I had a sense of the difference between just team work where everyone is doing the same thing versus many different roles.

Anne had worked on teams in a care home and employment counselling. Since she graduated she did counselling in schools and found that with a more interprofessional approach decisions were better informed. She described a situation where she and another employment counsellor had made a decision without involving the client:

> I referred her back to my co-worker who was working individually with people because I didn't think she was ready for the job developer. And I think, I don't know if she actually even went back to her so we referred her without discussing with her whether she wanted to work with someone or not but I think she let us know she didn't want to by not coming and so I guess just not having an

> awareness of whether, what we were doing would be most helpful for her even though we thought at the time it was but in hindsight we didn't do the rightful thing.

In her description of how she handled decision making in her current position it was obvious that she was careful to involve all the players in the decision:

> Like when I'm working with the speech path and special ed. consultants that's to get their view on things I don't think, like it might be that it is more than my area that I need to make the ultimate decision. But it might be that the difficulty that they're having might go to the speech path and they'd be doing their testing and make the ultimate decision. So I don't think it's always resting on me. But the other thing is – I forgot actually about the interprofessional relationship between the teacher and the resource teacher as well – because if it is in my focus in my area and I'm doing the testing with the student, I still then get information from the teacher and resource teacher and the parent as well. "What is your take on this?" When I'm getting the results, I say "Does this kind of fit with what your thinking is? Is there anything else we should add or have I talked about something in here that doesn't fit with your experience with the student? And so I actually think it's kind of like a team effort. Like I've done the actual testing but they have the practical experience to bring to it? They've seen the student or their child, day in/day out and I feel like they contribute a lot as well. And I write up the results but I talk about it with them and say "is there anything missing that you think that should be in there? Is there anything that doesn't speak to what you think is happening?

Anne stated that she did not believe that she made the decisions herself; she felt that she was informed by those who were involved. She also recognized that when others had the expertise in the issue they would be the ones to have the final say, as demonstrated in the above quote.

Anne was able to make the distinction between multiprofessional teams and

interprofessional collaboration after she reflected on the difference between her work in the care home and what she was doing as a psychologist in the school system after completing her PhD. While she saw both workplaces involving team work she identified that collaboration was required interprofessionally to come up with the whole picture of the issue and intervention that was required.

Experience with interprofessional group or course.

Sophia was a part of the Geriatrics Interest Group started by a student in Medicine. In keeping with the example set by the Geriatric Assessment Unit the Geriatric Skills Day was interprofessional in nature.

> Um, I guess since joining the college of medicine I took part in a few different student groups that were interprofessional like students from various colleges. The main one, the one that I was most heavily involved with and the one that I had the most interprofessional experience with was the Geriatric Interest Group and that's a really great group. I had a chance, they put together a Geriatric Skills Day and there were different workshops put together and a lot of the workshops were interprofessional involving two different health professions working together and then the day in general was interprofessional and at the end of the day ended with a PBL session that was also interprofessional. There were different students attending and there were also health professionals from the various disciplines teaching and working together. Geriatrics is very team based and they do a good job of being interprofessional there at City [Hospital].

When I asked **Sophia** what she took home from the conference she said that she realized she was still confused about the definitions related to professions and disciplines and multidisciplinary versus interprofessional practice.

Coffee had taken part in an interprofessional course:

> In one of our social work classes, it was part of the class for - the first time social

> workers were involved in it. It was four or six weeks, one or two days a week. I'm sorry, it was a couple years ago now but people from Social Work, the College of Medicine, um, Kinesiology, Physical Therapy, Nursing got together at RUH in Ellis Hall there and in the theatre there and had kind of a, they put you in groups of one discipline per group and kind of went through of what we thought everyone else's roles were and kind of our biases of those roles or stereotypes we had of them and what they actually do. Yeah, it was kind of neat and kind of went over how we would work together in situations or case studies and stuff. So it was pretty interesting.

Coffee stated that it broke down the stereotypes of each health profession:

> We had a med student; I mean we had a few people, even me, before I got into social work kind of look at social workers as the quote unquote baby stewards. Kind of over checks with babies. So it was good to be able to kind of knock down those kinds of stereotypes. So then there is that, you kind of look at med students as maybe the uppity know-it-all God complex kind so it really kind of brought, knocked those down a bit and you know we went over stuff about poverty and stuff like that so it kind of got people a chance to talk together and it was good.

Earlier in this discussion **Coffee** was quoted as having a similar stereotype of social workers herself. She was not the only participant who mentioned the stereotypes of health profession students. **Gloria** also described stereotypes of doctors:

> People who are being educated to be doctors might be given the sense of their opinion in a health care facility, where their opinion is the most important because their work is the most important.

Karen also alluded to this stereotype when she stated that for her doctors and nurses were the main providers of health care.

Two of the participants had no previous experience in working with multiprofessional teams or interprofessional groups. Two participants had experience with multiprofessional teams

in the workplace and the remaining two had interprofessional experiences in their educational programs. All of them were continuing to develop their understanding of the differences in meanings of the terminology: multidisciplinary versus interdisciplinary, discipline versus profession and multiprofessional versus interprofessional.

What they brought for interprofessional collaboration.

I asked the participants what skills they brought with them for the process of interprofessional collaboration at SWITCH in order to learn about their *Fore-Having* and *Having-Been* (past). Their answers were varied but related to specific knowledge and relational skills. All of these skills involved effective communication.

While some of the participants identified specific knowledge that they brought in answer to the question above, some of that knowledge was embedded in their answers to other questions and will be discussed in a separate section. **Sally** made the point that "*not just assuming that people know what you're talking about"* was a part of good communication. **Coffee** stated that one must respect the knowledge of others.

Sally, a social work student, brought knowledge of the health care system with her from a previous job in home care. She had also taken a medical terminology course.

> I understand the Health, the system, how it works. But then my education, with my social work, tells me to see things from a social work perspective, obviously. And then I also took a medical terminology class a year ago because I knew I wanted to do social work in the health field so I thought that would help me so I took that through SIAST. So I think that is a skill that helps me to understand nursing and medical students lingo because they just say it, like you know, it's their background but a social work student would never know what half those words mean, you know? So even though I don't know a lot about what they're talking about, at least I have an idea and I can ask questions because I know a little bit. So, yeah, I think that is something important.

Sally made this point in the context of needing good communication skills to work in an interprofessional setting. If one does not understand the terminology that others are using it is hard to understand or to communicate appropriately. Not understanding how the system works could lead to unrealistic or incomplete contributions to the health care plan for the client. Lack of membership in a common language *Clearing* could challenge interprofessional collaboration.

Coffee brought knowledge gained from time as a nutrition major: *I've had, well I was a nutrition major for a while and I studied natural health just on my own…*

This learning could increase the span of her knowledge to overlap with other SWITCH participants more than the average social work student's would. **Sophia** described knowledge gained from a Reiki mentor and also about acupuncture as a way of expanding her respect for natural approaches to health. She shadowed a Nurse Practitioner and gained an understanding of the potential for that role in her practice. The holistic view of health respecting both the scientifically based and alternative therapies as well as the physical and psychosocial components was an important attribute for the participants.

Anne referred to knowledge of the area worked in as important for knowing what will help others in their work to maximize client success: … *Really having an overall view of what's happening and pinpointing what kind of information will help the next person based on their knowledge area.* In order to use this knowledge effectively one would have to know something about the next person's role in the work with the client.

Relational skills.

Effective relational skills were seen to facilitate optimum care. Each participant described at least one of these skills. Included in this category were seeing each profession as equal in value (equality) open mindedness, respect, and conflict resolution.

Equality.

Gloria's first thought about what was important to interprofessional collaboration was the belief that every health profession was of equal value with the others.

> If you keep getting doctors who think that their opinion is the most important: that a nurse is only there to serve - to carry out what they think should be done then, I don't think interprofessionalism will necessarily work or it will be such a kind of a culture shock to them so they have to learn that nurses aren't subordinate they just have a different role. That it's connected with theirs but on the same level of importance … and that understanding of the roles that they play I think will facilitate uh, a sense of the need to value the other person's opinion as equal to their own.

This perspective was consistent with **Gloria**'s political science background where she described horizontal relationships and it fit with her strong social justice orientation that everyone should have the health care they need the way they need it.

> There's one course I'm taking called Social Change and Global Solidarity and in it, we're looking at, I think it was Catholic social teaching and one of the writers was talking about global policy networks and how this could be something new that could help people who are disadvantaged and what he foresaw is that there would be horizontal subsidiaries so, um you'd have different groups so maybe local groups and government working together but, the important thing was that they be at a horizontal level so the authority of the government would, it would be about local organizations so, I guess in the same way with interprofessionals so they would need to be horizontal subsidiaries so the opinion of the doctor couldn't have more weight than that of the social worker or the spiritual healer, or, I guess, the nutritionist.

Sophia, a medical student, echoed the need to observe the equal status in the health care team: because I think that in the past that was the perspective is that the doctors ruled. But in fact that's not true at all. All of the different health professions have their own set of knowledge

and their own set of what they can do for the patient and

> I'm definitely not of the medical mindset that doctors are the kings and queens that's all extremely and equally important.

Sophia's statement is also in line with **Gloria**'s statement that:

> I guess in the same way with interprofessionals so they would need to be horizontal subsidiaries so the opinion of the doctor couldn't have more weight than that of the social worker or the spiritual healer, or, I guess the nutritionist.

The above statements took into consideration the differences in knowledge and approach of the various professions. **Gloria**'s description of stepping back from a choice experience to allow others the opportunity to participate and learn from it also contributed to equality. It is indicative of the underlying belief that all the volunteers should have equal access to appropriate learning experiences especially when they are rarer opportunities.

Open mindedness.

Part of treating each other as equals can be seen as being open to their knowledge and practice. In order for this openness to work the students had to have respect for each other and to listen carefully to what the other was saying. When asked what skill she brought to interprofessional collaboration **Sophia** stated:

> I think part of it would be openness. I've learned through my experiences at church and travelling and SWITCH to really be open to people from a variety of backgrounds, disciplines and schools of thought; wherever they come from because everybody has something to offer, for sure. So I think part of it would be openness and I mean at this point, I'd think I'm early enough on in my medical training that I am still partially a blank slate. So that openness is definitely still there.

Sophia gave an example of learning from a presentation on Reiki. She also appreciated the holistic view of health that she gathered from the "alternate" therapies. Her description of her

shadowing experiences showed that she really valued what she learned about the skills and roles of other health professionals and could see that they would fit into the care of patients:

> But I guess I could talk a little bit about my shadowing experiences in Med One. So I shadowed a nurse practitioner for an afternoon and a diabetes nurse educator. And I thought that both of them were phenomenal. They did a very good job of knowing their patients who they've seen for a long time. They were very conscientious, very approachable, great communicators, great teachers and great at treating the whole patient. So those are definitely services that I don't think I would be afraid to utilize and work with in the future for my patients.

The positive impression of the nurse practitioner whose role overlaps that of physicians demonstrated that **Sophia** was open to seeing what each had to offer for the benefit of the patients.

Anne also found openness to be an important attribute for successful IPC.

> So when you come from one certain view and then another professional comes from another view - having an open mind to hear both parts in how they contribute to the same goal. I think having the counseling skills of listening and understanding other sides besides your own view.

Listening was an important strategy for achieving understanding of the other person's perspective and how it related to the common goal. Part of what helped **Anne** was what she described as being a social person:

> I think just one other thing is just my personality towards working with others; I think I've always kind of had the inclination. I'm a very social person and like to get ideas from other people rather than just being alone and this is the way I'm going to do it. So even before I'd been in any professional experience or training I think I always kind of tended towards that way.

Anne came with the perspective that it was better to do things together. This understanding oriented her toward collaboration in her work. Her openness assisted her to work

on a team consisting of people with different backgrounds and knowledge working together to achieve larger goals.

Two other participants illustrated the importance of listening. **Karen** loved listening to the stories people told; both clients and the other SWITCH volunteers. Her interview read like a series of stories as well. When asked what skills were necessary to provide good health care, given a commitment to interprofessional practice **Gloria** replied:

> Specific skills or characteristics – I guess good listening skills. Although I don't know how that would – being able to realize the value of other people's contributions and, I guess a barrier to that right now I think is how maybe the different sectors are educated.

Gloria expanded this concept to that of one profession valuing the input of another and stated that she thought that doctors *might be given the sense of their opinion in a health care facility* and expressed her belief that the education programs needed to change their models to facilitate interprofessional collaboration.

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> I remember making rounds with doctors and playing the "Doctor Nurse Game" (Stein, 1968). We nurses often knew what the solution to the patient issue was but it was out of our scope to order. We were very adept at presenting the information so that the status quo would be maintained and the patient would get the care needed. At the same time we understood that the knowledge of our profession did not prepare us in the same way that doctors were prepared. This understanding was part of the reason that we did not tell them outright what we thought should be done: what if the limits on our knowledge had drawn us to an incomplete or erroneous conclusion? There was one group of doctors with whom we could have collegial discussions about the patient and the interventions without shaping our presentation of the facts and observations to

achieve the results we thought would work in the patient's favour. These conversations were more open and straight forward due to the mutual respect.

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Respect.

Closely related to Openness is the concept of Respect. **Coffee** described herself as being opinionated and, like **Anne**, believed that it was particularly important to respect the views of others when they did not agree with hers:

> **Coffee**: I guess just personally what I bring to it is just my ability to respect other people's opinions, not bombard them with my knowledge, like my opinions all the time just those communication skills – letting other people talk.

In order to respect other people's knowledge she had to listen to what they had to say. She also saw this respect as relating to knowing where the boundaries lie for what she could and could not say to whom. In her assets for interprofessional collaboration **Coffee** included the ability that she gained over 15 years as a manager to assist the group to stay on track: *15 years as a manager so I kind of have that kind of, that ability to win everyone's kind of losing focus to try to get everyone back on track sort of thing.*

Of the six participants, **Coffee**, **Anne**, and **Sally** had the most experience and talked the most about relational skills other than equality. While **Coffee** described respecting others' opinions and boundaries, **Anne** was oriented toward maintaining congenial and constructive relationships.

Respect is also a part of professionalism which **Gloria** believed was an important requirement for working in an interprofessional environment:

> I think it [respect] is in a, a situation like professionals assign themselves in at SWITCH. It's really clear why you need your professionalism because you'd see people coming in who do need a social worker as much as they need a doctor so

> for any professional who comes into SWITCH it'd be very clear to them why, why it's important.

The concept of professionals respecting each other's skills and knowledge was seen as an important part of the interprofessional practice in the SWITCH setting because of the multifactorial influences on health. Related to professionalism was effective conflict resolution. If one respected the other then one would try to resolve conflicts in such a way that the working relationship could continue to be successful.

Conflict resolution.

For **Anne**, a critical skill for collaboration was conflict resolution:

> Being able to work as a team and actually at that job there was a time when I had a conflict with someone and it wasn't the route, right. You know, arguing about something, it was just some tension that needed to be solved. And I've always taken that learning experience when I go forward and whenever there's something like that happens again. Because it's hard to work interprofessionally if there is that tension. And so just the way I dealt with it, I thought it worked fairly well and so keeping that with me for future work.

Anne's description of her work experiences was full of working together with people and problem solving to provide results in a positive atmosphere. She stated that since she was a young girl she always tried to smooth relationships among her friends:

> Conflicts when you're with friends when you're growing up – I always wanted to smooth everything over. Let's resolve this, we're not just going to not talk to each other, you know, so, that kind of informs it too.

Anne explained that she had to take time to think the situation through before she would attempt to solve the work conflicts. When in a new position she experienced lack of certainty with her role which challenged resolution of conflict with another person. It was not always a full blown conflict that she successfully dealt with. At times it was just personal differences:

> It's interesting bringing different personalities together because although I work well with a large variety of people, I think I have had a few different times where I had to kind of work differently with someone or you know find a compromise because of differences in personality.

In these cases **Anne** used compromise and adjusting her approach to maintain the working relationship. She found her supervisor to be helpful because they had the same approach to work.

The *Clearings* for the skills and values that the participants brought to the interprofessional practice broad and varied but similarities existed at a larger scope. All of the participants came into SWITCH with values and experiences that led them to believe that the 'Multiprofessional' approach were was not the optimum practice to achieve healthy patients. Each one found her answer to the issue of fragmented health care to be interprofessional collaboration after learning about IPC. Each felt that the knowledge she had gained formally or from life experiences contributed to the ability to collaborate with other professionals. In particular the more experienced participants focused on the relational skills that they had developed. They saw these as using the skills and knowledge that each team member brought to meet the common goal.

Clearing: Interprofessional Collaboration at SWITCH

The discussion of interprofessional collaboration by the volunteers was guided by Heidegger's concepts of *Modes of Involvement* (Leonard, 1994). The first mode was that of *Ready-to-Hand* in which things were going smoothly and there was not much conscious awareness of how they were going. In the second mode, *Unready-to-Hand*, the process broke down in some way and the interactions practice, or process came to the foreground in consciousness. The third mode, *Present-to-Hand,* included stepping back to reflect, theorize, experiment or study. These interviews provoked memories of all three modes for the

participants.

When everything goes smoothly.

When I asked the participants about the experience of the clinic running smoothly, two of them answered by describing the work processes at SWITCH, while others referred to parts of those processes. Embedded within other responses was the inference that processes set up for the clinic worked well at those particular times. One participant included a short list of events that would not happen on a good shift.

The clinic process.

Sally gave a detailed description of the basic clinical process:

> Well, a client will come in and briefly tell the shift supervisor what they're there for and the shift supervisor will go into the clinical room and tell us what, communicate to us what the client has said and then we will figure out which student should go or what.
>
> – Yeah and well then we go into, us students go into the room and sometimes the mentor will be, okay what are you going to, how are you going to present your questions or what aspects are you thinking that you might look at just from the little bit that the shift supervisor has said. So then we'll talk out loud a couple minutes, maybe 5 minutes if it's an in-depth case and then us students will go in and introduce ourselves and talk to the client and then come back to the clinical room and talk to the mentors and the mentors will, you know, especially for medical, the mentors will say, well, I think it's this, this and the doctor or the pharmacist will and social work will talk a little bit with their mentor and the mentor and the students will go into the room and discuss the situation with the patient and give a prescription or the social worker will set things up.

Accompanying each step of the clinical process was a conference with the whole clinical team. The shift supervisor and clinical team determined who should conduct the clinical interview and examination. One of the important considerations was that the client felt

comfortable with the SWITCH volunteers who were in the room.

Sally:

> Yes, sometimes clients don't want so many people in the room so in that case, if it's a social problem, then the mentor and the social worker student will just go into the room. Or else if its, you know, they don't want to talk about the social aspect, maybe we would decide. Well the social worker student wouldn't really need to be there. So we're trying to eliminate if the client isn't, because lots of clients aren't comfortable with like 5 people in the room – which is normal and so we'll eliminate people that we don't think need to be in there. And then they'll come back, the mentor and the students will come back into the room and we'll discuss it again how the client received the information and what the client is going to do. What our role or what we have to do. If we have to make phone calls or … so then, even if we're not in the room, we're still getting the experience of the situation. Which is something important and I really like that.

Sophia gave more detail of the role of the shift supervisor:

> With SWITCH I've only recently started being a shift supervisor. So that's the person who first does intake with the client and then sort of triages and talks to the clinical team about the clients – presents the client's case to the clinical team – and then decides with the clinical team who is going to go in and see the client. And then kind of follows up with the clinical team to make sure that client gets treated.

Once the information was collected those who were with the client presented the case to the rest of the clinical team. The first volunteers returned to the client with the clinical suggestions for the client to make decisions about. When the client had made his or her decisions the whole clinical group received a report of the last interaction.

This process was an important learning experience for those on the clinical team. Due to the need for confidentiality and respect for the clients, much of the information could not be

shared with those volunteers who were not on the clinical team. To involve the social team members in the clinical side of SWITCH there was a debriefing session at the end of the shift in which all the volunteers described the experience that stood out for them.

> **Sally**:
>
> The debriefing is really, really good and I think it's good for the social team too because its, they, the adults couldn't come to spend an hour with us if they had their babies with them, or their children and so if the day care wasn't available, they wouldn't have time to spend with us. Or else, like if the food wasn't there, lots of them wouldn't be there. And then the programming, if the programming wasn't available, that's like drawing cards to get people in, you know. And with the Women's Night starting up, I think that's awesome and like lots of times they've attempted to do men's programming, you know but men aren't into it as women. But I just think all the things that the social team does and the things that council and the things that us students set up, aside from the clinical aspect is what gets people in to talk to us.

Permission was given by the client at the end of the clinical visit for any information that was reported about the individual in the end of shift debriefing. No names were used in this report.

> The above process was also described from the perspective of a social team member, **Karen:**
>
> Well one more thing at SWITCH, I'm not really part of it but it comes to my mind. You know how they, someone comes in and someone will take an interview like ask what their problem is and they will go and discuss it with all the interprofessionals being in one room and then they discuss – so this patient has this, this, this and this problem. One will take that, the social worker will see the social point of it and she will take that and the doctor will be like, you know if it's a medical point the doctor will take that. So I'm not really part of that process because I'm still category A so I think that happens too. |So before actually seeing the patient there is someone who goes and ask "How can we help you

today?" And then right away they will discuss that with everyone else and then they will take the patient accordingly. So I like that too – another process within the whole process that they do.

For not being a member of the clinical team, Karen had an accurate perception of the clinical team process. Her approval of the clinical process was consistent with the excitement at going to see her doctor and being able to just walk down the hall to talk with a nutritionist. To her, having health professions work together was a convenience for both the client and the health care team.

This mode of involvement is known as *Ready–to-Hand* (Leonard, 1994). The participants were enthusiastic in their answers to the question concerning the experiences smooth functioning. They described the expected process and measured success in relation to the occurrence of preferred outcomes such as the process running smoothly, opportunity for significant learning experiences, appropriate care being provided, and being busy. Some also reflected on what the real "good" was about in the experience.

Some of the responses to my question of "What is a good shift like?" or "What is it like when it goes smoothly?" were descriptions of the process working as it was meant to. **Anne**, who had worked in multiprofessional positions and now in an interprofessional one in the field of education, described an interprofessional experience that she had as an employment counselor:

> – I was thinking of one in particular as an employment counselor. Just a time when we helped someone find a job and they kind of used each of myself and my co-workers at some point so we really came together to be able to help this person find what they were looking for. (quietly) What about it worked well? It's kind of difficult because I always think as an employment counselor it's also the motivation of the clients that in part or is part of it that they're motivated and really want to find work as well. But I think just really being open with each other about what's happening for the person I guess. Because my one co-worker worked with a client individually who we decided could use the group I was

> running and the group is about exploring, you know when people are kind of stuck they need a change in careers for whatever reason, and so through individual counseling, my co-worker figured out that this group would be really helpful for this person because they were stuck and so just really giving each other details about. So she'd tell me about, kind of, the background she'd gathered already. What she thinks could be helpful for this person. And so then I did the group with them and then through the information I gathered through that group, I passed it over to the job developer because by the end of the group she was ready to just get out there and make connections with employers and find work. And so there again, me providing what she's changed throughout the group and what she's learned and what she's wanting to do and then the job developer was able to help make that connection on the job she was really wanting. So I think the biggest thing is the openness between the team members to be able to have – to provide the right kind of details about the person to then move forward with the next stage.

Anne remembered this as working well but had to think about what had contributed to the process working so smoothly and achieving the results for the client. When I asked her how she knew which were the details that needed to be passed on she stated that she had learned from the times it had not worked well. She then stated that keeping in mind what area you are working in was key:

> I think just knowing what area you're working in because it would be very different for what you tell someone for educational, psycho-educational assessment versus finding someone a job. So knowing what kind of things will lead to helping that person find a job. Are there certain barriers in their way so when their first person was working with them knowing that they had too many barriers to just work individually but this group works on many different aspects of career exploration would be more helpful? And so letting me know about that background that would affect the group, I guess. And then how that's changed throughout the group and where her level of readiness for looking for work is then

> to share with my co-worker that helped her find work. So like it's different for each situation but I think really having an overall view of what's happening and pinpointing what kind of information will help the next person based on their knowledge area. So the same as ed. psych – if I was doing an assessment and felt like there was an area that a speech path would more, be more helpful in, then I'd provide that kind of information and difficulties related to speech path. So having knowledge of the other person's area, I guess.

Anne extrapolated from this specific experience to her current position as an educational psychology counsellor and by doing that was able to pull out the essence of reason for success, that of knowing about the person's needs, the roles, and the capabilities of other professionals, and her own area.

Coffee also described the process working out well on a good shift:

> It goes great. You feel like everyone accomplished what they wanted to accomplish and they, well you feel like the client got everything that they could have from the experience and didn't feel… When it goes smoothly, the client doesn't feel overwhelmed and you can tell that there's a good relationship in the room and everything just flows nicely and the client needs are met to the best of your ability and you leave the, you just kind of leave the exam room feeling "that was a good one". You talk in the room, the clinical room, about it. You maybe learned something you didn't know before or you got to tackle a kind of tough question or you know when everyone got to use some kind of skill or something from the experience and get to share it with everybody. That's when it goes smoothly I guess.

Coffee not only considered her personal experience as the measure of success, but included the positive experiences of others as an estimate of a good shift. I asked her what made it go smoothly and she responded about what it felt like, and then with some criteria for those components of a good shift, the foremost one being that it was "all about the client":

Katherine – Do you have a feel for what makes it go smoothly? What the ingredients are those that make it go smoothly?

Coffee – I think it's when you're in the room it's when you can tell – it's all about the client. You can tell – it's their body language. It's what they're saying; it's what they're sharing. I mean when they tell you – asking them at the end if there's anything else, just kind of getting that feedback from the client that it was a good experience and I mean it doesn't have to be like this huge ordeal where all three students in the room go to tackle something big but someone came in with a complaint and it was met. You know, their needs were met. Or there was an extra need found and that was met or something. That's kind of, you go back and you just all feel like we did what we needed to do and it was good.

Katherine – And then you have the opportunity to debrief afterwards too which sort of cements that feeling.

Coffee – Yeah and then you get to share with everyone based on if the client allows it, kind of what happened and it feels good to be able to tell everybody that it went good and it's, yeah the other students like to hear that, to hear what you did to make it feel good.

Here **Coffee** echoed **Sally's** concern that the members of the social team have the opportunity to share in the success stories.

Busy shift

A busy shift provided diverse experiences for learning. **Karen,** always enthusiastic in her responses was even more so about a recent shift that went very well for her:

On a good day, it's good because you're not just stuck doing what you're doing, you know, to get to change every so often so the last time I was there, it was quite busy and there were lots of volunteers. Not last time but last last time – I think it was three weeks ago I guess and there was lots of volunteers and lots of people – way busy. And, uh, I got to change my place. At first I was working in the kitchen – I really like that – and after that I came down and took attendance for a

> while and then somebody else came and took over for me and I was just sort of sitting there and talking to people and just socializing and then after that I went to the sharps van so that day was so interesting to me because I got to do different things and I loved the SHARP van. It was great!

Most of Karen's good experiences came from learning something. On this shift she had the opportunities to listen to people in the waiting room, to be responsible for recording the shift attendance and to be involved, mostly by observation, in the needle exchange program, SHARP. She saw the consistence between the approach of the staff working with the SHARP program and the goals of the program. She also got teased by the people with SHARP (HIV Aboriginal Reduction of Harm Program), which increased the enjoyment of her learning.

Being busy was also a component of a good shift for **Sophia**:

> Well first of all I would say busy. Not too busy that we can't handle it but busy that we have a good flow of clients and we can feel like we're serving, we feel like we're serving people and there's people accessing our services.

For Sophia, a good shift was not only about learning, it was also about helping people. She added the absence of events that would make a shift less positive.

> *I guess no problems, no incidents, no attitude problems, no difficult clients.*
>
> *Katherine – Difficult as in?*
>
> ***Sophia** – Difficult, just in hard to get along with.*
>
> *Katherine – Not difficult as in complex medically?*
>
> ***Sophia** – No not as in complex medically.*

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I witnessed a "difficult", aggressive client trying to start a physical fight one evening in the clinic waiting room and wondered how it would be dealt with. I could understand how that would disrupt the smooth running of the process. It was handled efficiently by the receptionist. SWITCH has a

> policy of no tolerance of abusive or aggressive behavior and the receptionist articulated the policy, including the admonishment that if it did not stop immediately the person must leave. Much to my surprise and relief this soft calm voice was obeyed immediately.

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Sophia:

> And then in terms of the clinical team, a team that works together well, that's open to each other's ideas; that bounces off each other's ideas; and has a good steady flow of clients but still does a good and thorough job and considers a lot of different perspectives when treating each client. Yeah I guess that's most of it for the programming and the clinical components.

In the above quote **Sophia** clarified what else was necessary to make a busy shift a good one. The components of working together, building on each other's ideas, and considering multiple perspectives were also indicative of effective interprofessional collaboration.

A good shift or one that went smoothly was one in which everyone's needs got met. Sound decisions were made jointly by the clinical team. The volunteers on both teams had opportunities to learn and no one had to sit around waiting for things to happen. The clinical team and social team members shared successes such as learning and client outcomes with each other in the debriefing.

When the process breaks down.

Most often when the question about the breakdown of the process was asked the participants had to stop and think for a while. Some really struggled to find an example. Situations described involved not enough to do or learn, losing clients, client incidents and differences in values and perceptions. Whatever the breakdown the volunteers dealt with it by reviewing what happened and searching for solutions.

Not enough to do or learn

Sally's example of a breakdown in the smooth running of the shift was related to the lack of learning and input for the whole team when a client preferred to have fewer people in the room for the assessment and treatment:

> Yes, sometimes clients don't want so many people in the room so in that case, if it's a social problem, then the mentor and the social worker student will just go into the room. Or else if it's, you know, they don't want to talk about the social aspect, maybe we would decide… Well the social worker student wouldn't really need to be there. So we're trying to eliminate if the client isn't, because lots of clients aren't comfortable with like 5 people in the room – which is normal and so we'll eliminate people that we don't think need to be in there.

For this example of a shift not running smoothly for **Sally**, there was no review or solution because the process was set up to provide client centred care and they followed it. Surrounding the client with health professionals and students that the client did not want or need would be counter to the desire to 'do good' for the clients. In these situations the learning for the students took second place to the needs of the client.

Other examples of poor learning experiences were related to not being busy.

> **Sophia:** Well there are some that are just very quiet… There definitely can be incidents. There can be incidents that happen with clients who are hard to get along with. Yeah, it's definitely on the two extremes of too quiet or too busy and too quiet we just don't have enough to do for the volunteers and the mentors. We don't feel like we are meeting the needs.
>
> Katherine – So what do you do?
>
> **Sophia –** Lots of times sit there. I think, be bored people. Wait for something to happen and nothing does. We stay open as long as we normally do but just at the end clean up quickly because you know we would have been able to start before the shift actually closed and debrief. Say, okay, this was a quiet shift; I wonder

what we could be doing differently or what circumstances are out in the community right now.

Sophia described what it was like when the clinic was not busy. She identified boredom and she also worried about why people were not coming to the clinic. From her answer it can also be seen that the students still maintained the clinic hours when no one was using it.

As was illustrated before, **Karen** did not like it when the clinic was slow.

Katherine: So have you been at SWITCH when a day hasn't gone well?

Karen: Not really, no, no. Um, I get to relax I guess? This one time it was Wednesday evening, it was last semester, I went there and it was very slow and I sat at the, um, the old building, they had like, fruit or vegetable shop and they would sell stuff for like really cheap. It was sponsored through CHEP and so I would sit there and not many people came. Maybe one or two people, I don't really remember. They bought bananas and I took them ant that's it – it was very slow. But that day I was really, really tired too and I had classes all day and I had a lab and then after there for the whole four hours, it was good. I got to think and I got to relax and I got to say "Hi" to so many people coming in and out so no, no that's one day that comes to my mind that was slow and I felt like I'm not really doing anything.

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While I did not explore this with the study participants, the activity and attendance of events in this community slowed down according to when the cheques come out each month. This was a factor that guided the scheduling of events in my clinical practice with "my" students in community health clinical practice. The other reason for low attendance that I have noticed and the participants confirmed was related to having no doctor or nurse practitioner in attendance at the clinic. As the participants have pointed out, most clients "present" with a medical issue.

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It was interesting that **Karen** immediately equated a slow shift with a day not going well. This was in keeping with her preference for a busy shift with lots of variety. Consistent with her enthusiastic approach to life, **Karen** opted to look at the positive outcome for her when the shift was slow. Slow shifts and lack of clients to see made the students feel like they were not meeting the needs of the clients and themselves. This definition of a breakdown in the functioning of the clinic added emphasis for the participants.

Lost clients

Anne gave an example of losing a client for a shift that had not gone well. This event did not happen at SWITCH but when she was an employment counsellor. Anne described the programs that the clients progressed through at this agency and the pathways to communicate the progress of the client and her readiness to go to the next stage of the program. Anne described the programs that the clients progressed through at this agency and the pathway to communicate the progress of the client and her readiness to go to the next stage of the program. The client disappeared and did not return to the program. **Anne** reflected on how they lost her:"…And I think part of that was knowing the person's ability to make it through - the way the group worked."

The concern for **Anne** was whether the employment team had not read the client properly and the client had decided not to follow through for her own reasons. She continued on to describe how she and her colleague reflected on what had happened and how they could avoid a similar incident in the future.

Sophia also wondered why clients were not continuing with their health care:

> There's some where it's kind of sad to see clients for whatever reason aren't opening. Like clients that start the clinical process and then stop – just chose to leave- don't choose to accept the services that we have to offer.

The loss of client's mid-treatment was such a significant event that such experiences were evaluated and reviewed as were undesirable incidents.

Incidents.

Sophia and **Gloria** stated that incidents that put clients at risk broke the smoothness of the shift.

> **Sophia:** There definitely can be incidents. There can be incidents that happen with clients who are hard to get along with. Yeah, it's definitely on the two extremes of too quiet or too busy and too quiet we just don't have enough to do for the volunteers and the mentors. We don't feel like we are meeting the needs.
>
> Katherine: What about in a shift where the bit that makes the shift not go as well is someone that is difficult to get along with? What do you do then?
>
> **Sophia:** Well first off make sure that everybody, all of the volunteers and all the other clients and all of the mentors are safe and try to dissipate the situation as quickly as possible. Whether by asking that person to leave or by addressing the conflict, addressing the situation and then in review making sure that the appropriate things were done to handle the situation and the appropriate safeguards are in place to make sure that everybody was safe while that happened. And maybe appropriate safeguards, if possible, to stop it from happening again.

Sophia's example of an incident was one in which a difficult client endangered the safety of the clients and the volunteers.

Gloria had to think about a time when something happened to disrupt the shift and came up with an example of a child being injured in child care. This story is from the interview when I forgot to turn the tape on so it was paraphrased and was shown to **Gloria** for her approval, which I received:

Gloria stated that when things did not run smoothly, things did not go on as planned and time was needed to rethink and adapt. As an example she described playing a game with the

children. One child's nose started to bleed and there was concern both for the child – what to do, but also that something they had done had caused the nose bleed. This was of particular concern for one of the other volunteers who was not seeing it as something that sometimes happens to children. In this case, Gloria and others involved evaluated what they were doing to see if it was the game itself that was problematic or something that happened as a result of playing the game – should they not play that game again? Gloria stated that this has been the only time that she has had any kind of incident that was not positive during her time with SWITCH. She described having homework to do that evening when she got home and having trouble getting to do it.

The childcare room was well equipped with toys and other things to keep the children entertained but there was always the possibility that children would have accidents or "rough house" and receive injuries. The incident provoked reflection on the part of the volunteers who were involved. This incident demonstrated how closely related the modes of involvement were, especially the *Unready–to–Hand* where the situation breaks down and a review or evaluation results in the *Present–to–Hand* mode.

Interprofessional relations.

The citation of difficult interprofessional relationships was rare in the interviews: only two were discussed. Both incidents worried the volunteers enough that they were a significant part of the end of shift debriefing. **Anne** and **Coffee** contributed these examples to the discussion of concerns with the smooth running of the clinic.

Anne identified a problem related to the members of the social team not feeling as if they were making important contributions:

> I guess at SWITCH there's been a couple of times where the social team – the people that are out in the lobby – greeting people – which I think is a most integral role. That they often feel that they're excluded, kind of, almost. Like

> there's this clinical team that sits in this room and works with the patients in a, like, medical or counselling, that kind of thing. Whereas with them, they're chatting with people and they feel like they're not maybe contributing – when we actually think they're contributing the most; but it's hard to get that across sometimes.

Anne and others on the SWITCH Council looked for approaches that would show the social team members how important their role was to SWITCH.

One other event that has already been presented was seen by **Coffee** as a cause for the breakdown of smooth functioning of the clinic:

> I would say I've been there one day that it didn't go smoothly but it had to do with the clinical team itself – but it didn't have to do with the client or, I mean our client situations are very… I mean anything can happen. You can't really call any of it bad unless something horrible happens because it's all what it is. But there was one instance where there was a mentor that was actually, that made everyone feel uncomfortable. It wasn't a student and that was about it. No one really knew how to really comment on, kind of their opinions, don't know what they were saying or anything like that. But I think that would be the only time, was when we had a mentor whose values and philosophies didn't jive with SWITCH at all and it just kind of cemented the fact that everybody at SWITCH does have the same philosophy and values because everybody in that room was uncomfortable so it wasn't…yeah, so definitely it kind of brought back the fact that SWITCH is maybe unique or does share or the people that come in do share certain values and ethics and have to have them to be there - or else it's just not a good fit.

Coffee was very concerned about this divergence in values between the mentor and the volunteers but the positive aspect of it was that it made the volunteers realize that they did have common values and that being like-minded was significant to the smooth functioning of the clinic.

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Coffee was concerned re confidentiality and anonymity during this interview. She was worried that the people that she talked about would be easily identifiable. For that reason I did not ask her to go into more detail about the specific values that the mentor violated and have not included the whole statement.

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Evaluation and review.

This section is related to the *Present–to Hand* mode of involvement. Often when the participants portrayed a breakdown in the function of the clinic they would end with describing an evaluation or review as a vehicle for addressing the difficulties. As can be seen in **Coffee'**s last picture of things not going smoothly the volunteers evaluated their experience at SWITCH positively and attributed it to the shared values and ethics. Both **Anne** and **Sophia** described colleagues wondering why clients just disappeared without completing therapy or programs and what they could have done differently. **Gloria** stated that the students reviewed the possible injury of a child and the circumstances surrounding the incident to determine if the situation was inherently unsafe and if the game in which the nose bleed occurred should be played again. The clinic process lent itself to the review through the mechanism of the end of shift debriefing session.

Another example that one of the participants gave of evaluation was **Anne's** reflection on why some of the social team volunteers did not continue with the program and what could be done about that. **Sophia** thought about why some clients did not continue with their therapeutic care at the clinic. **Anne** described exploring why a client dropped out of the employment readiness process. Each time the first question cited by the participants was related to what they had done to produce this result.

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Using Heidegger's philosophical approach to understanding as a guide for the questions has resulted in considerations on my part that I may never have thought of on my own. I say this specifically because initially I just wrote literally about the findings. Then, upon reflection on the underlying Heideggerian concept I was able to see how the stories related to each other and to the whole study. The reading, writing, re-reading, rewriting… of the hermeneutic circle was an integral part of this illumination. When I started this writing I did it with the belief that I would just write one or two drafts of the whole findings chapter and it would be done.

In a way I was forced to reflect over and over on the findings as health issues on my part, my parents' parts and my partner's part interfered with my focus and writing. In addition my mother's death during the process and working full time, as well as a move for health reasons, resulted in less than optimal amounts of time away from the findings. This frequent separation from the participants' input and what I had written meant that I had to read and reread whether I wanted to or not, just to keep the flow of ideas on track.

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What interprofessional collaboration is like

I looked for the understanding and meaning of interprofessional collaboration in a primary health care setting by asking what the participant's understanding of interprofessional collaboration was, what the meaning of the experience was, or what it was like, or a combination of the above. Not surprisingly the answers fell into three categories: Understanding, Meaning, and Feeling. The understanding, meaning and feeling were also offered by some of the participants before I asked the questions.

Understanding of the phenomenon

When I asked about the understanding of interprofessional collaboration the participants

answered with their perceptions of what it was or what they learned from it since volunteering at SWITCH. **Anne** began with a statement about what she did not know:

> The one I was talking about was my first interprofessional. But before that I don't know if I had a sense of; I had a sense of team work but I don't think I had a sense of inter-collaboration. I don't think it really entered my thought process, really so I'm not really sure if I had an idea of what that looked like before I actually was in it? And I have never really learned about it in classes or in programs. It was, actually was, when I went to a conference for SWITCH earlier this year that I really…Well actually it first was SWITCH where they really talked about it a lot and then there was conferences here too. So, I guess just my first interprofessional experience where I was exposed to it so I didn't have a sense before that but when I had that first job I had a sense of the difference between just team work where everyone is doing the same thing versus may different roles.

Anne's first experience of interprofessional collaboration brought the understanding of the distinction of different professions contributing each one's expertise to the common goal as opposed to a team of people doing the same things. She also clarified that perhaps not all people treated the work she did, as a true team effort, but she made sure that she included everyone in the information gathering and decision.

Anne defined interprofessional collaboration as:

> *I think many different disciplines and professional areas working together to achieve the same goal. In the areas that I've ever worked in, it's to help people in some way. Make a difference in some way depending on what you're doing. But I think there is also interprofessionalism in other things – even when you're not working with people but just for the same goal or whatever in organizations try to achieve a common goal.*

In an earlier statement **Anne** gave an example of a common goal in her work with helping women find jobs as the woman finding the job. There were at least two other counsellors in this

process, each with her own sub-goal but the overall goal was shared by the three counsellors. The client did not complete the process so perhaps was not ready to meet the goal, even though she initiated it.

Anne's earlier deficit in understanding interprofessional collaboration in contrast to her current experience with its effectiveness led her to bemoan the absence of the concept in her program:

> I think there is a gap, for sure, in my program. I don't know about other people's programs where there is not a lot of it talked about interprofessionally. I think that would be really important because like I said, until I was thrown in it – I didn't really have a sense of it. When I worked at Cosmo and I had already gone through a 4 year degree and I had never really gotten that sense of whole interprofessionalism when that's kind of where I was headed all along but I didn't know. Yeah, I don't know if other programs have it or not but I just think it's an important thing that should be implemented. I know some places are – because the conference I went to – they were talking about that. How they've implemented it. I don't think that helps my thoughts.

Anne's use of the phrase *"I was thrown into it"* echoed Heidegger's concept of *Thrownness*. As a counsellor she was put into the interprofessional milieu with very little preparation except her experience with team work in a care home and she found this difficult.

Although **Karen** equated health care with nurses and doctors she could imagine a broader concept of the professions that could be involved with the SWITCH clients. Consistent with the determinants of health model, she believed that at SWITCH even lawyers would be an acceptable part of the interprofessional team:

> I'm really biased towards nurses and doctors. Like I kind of, for me in my mind, people come to see nurses and doctors and then the doctors or the nurses will refer them to the social worker, nutritionist or to, you know, is there representation of

> lawyers or anything like that in SWITCH? I think there was one mentor there one time.

She went on to remember being told about law and accountant students taking part in SWITCH. This discussion reflected the intersectoral nature of health.

Coffee's understanding of interprofessional collaboration was consistent with **Karen**'s but more detailed, likely due to being in her fourth year of her professional program:

> Well I guess my understanding of interdisciplinary collaboration would be that peoples' issues aren't one sided and we, you have to take a holistic view when you look at health, when you look at mental health, spiritual health, emotional health and if you don't address all of those issues, you really can't address one of them. While it does happen in the work place, it doesn't happen to the extent it should.

Coffee also saw the connections between components of health and the need for holistic interprofessional care. **Coffee's** understanding of interprofessional collaboration included the knowledge bases of each profession as well as the relational requirements for this mix of professionals to work together effectively:

> I've learned, kind of, how to work in that team where everybody is kind of expert at their own knowledge and giving people the opportunity to have their moments to do, kind of what they do without judging them or stepping in and be a know-it-all and having the opportunity to be the expert of my knowledge while still letting the client run the show, if that makes sense? Kind of not forgetting who's actually the important person in the room with having so many people in there just being really, just cautious that you don't overstep your boundaries while respecting each other.

Coffee's concept of the client as central to collaboration brought out the understanding that everyone's expertise is needed for the client to be healthy.

Sophia described her perspective on interprofessional collaboration as having deepened

with her volunteer work at SWITCH:

> …more of check and balance system than it did before – just different people thinking from a different perspective and aspects of the person's health and of what could be done in the plan. Yea, it's just a lot about people working together and forming a plan together and everybody takes responsibility and is in charge of their own separate component but it's all – there's a bigger image in mind I guess. Yeah, um, I don't know how, yeah, I think the perspective I've had is just maybe deepened and I've gotten a little bit better of an understanding but I know I still have a lot to learn about what interprofessionalism is and how it can work.

While **Coffee** maintained the centrality of the client as the key to interprofessional collaboration, **Sophia** described it as a "*bigger image in my mind*". In other words, the client's needs were greater than what each team member alone had to offer from his or her expertise.

The common theme among the understandings of interprofessional collaboration was that of a group of people, each with his or her own body of expertise, working together with a client to achieve the overall goal of attaining or maintaining health. With the larger image of this overall goal, each team member focused on how his or her knowledge and skill could help the client achieve that goal rather than maintaining individual status or influence. Interestingly Shakun (2013) found that there is a spiritual element to connectedness and went further to say that it was also part of joint decision making. Perhaps the like-mindedness was a component of this phenomenon of interprofessional collaboration. Each participant perceived significant gain in this perspective through working at SWITCH.

Meaning

Each participant had an individually significant generation of meaning from her experience with interprofessional collaboration at SWITCH. This learning centred on insights about herself or her role and the contributions to client care. The meaning was strongly related to their value

systems.

The value that **Gloria** kept coming back to was that of social justice. She found this interprofessional practice was the way to even out the health disparities. She could not see how one could have an interprofessional practice without it being collaborative. She described the work of the interprofessional team as being bigger than personal needs therefore people would put these aside to collaborate in achieving the goal. **Sophia** echoed this concept:

> Yeah, it's just a lot about people working together and forming a plan together and everybody takes responsibility and is in charge of their own separate component but it's all – there's a bigger image in mind I guess.

Part of the meaning is to give up one's personal agenda for the greater good. They were rewarded for this by their belief, based on the popularity of the clinic, that they were making a difference in the community.

The participants found meaning in knowing that they were serving the community by helping people with their health. **Sophia** found that interprofessional collaboration meant they could serve the public better: she realized her perspective had deepened but that she still had *a lot to learn about what interprofessionalism is and how it can work.*

Karen talked about convenience for the patient and for the health professional:

> That would be so much easier and so much more convenient for the patient and the doctor rather than just thinking, sitting there at night, "what happened to that person? Did he or she go to the social worker? Did she go to the nutritionist, you know? Did he or she go and attend the doctor with what he or she is facing?" I just love that idea, you know? I never really came across that before; it's a very new concept for me.

She assumed that when health professionals collaborate the communication is such that they keep each other updated about the clients they have in common. This would give each one

the confidence that the plan was being followed and that the patient would be cared for effectively.

Sally had a similar idea when asked what interprofessional collaboration meant:

> I think I'll maybe sleep better at night knowing that my clients are getting the best care that they can get whereas you know, if a client comes in and they're on medications or I don't know much about mixing them but a pharmacy student or pharmacy mentor will be able to explain the side effects and then the medical, you know, like I don't know, working together as a team is good. And it helps me to understand the client better because the medication could, be causing a side effect in their mood and it's not them, it's the illness or it's the medication that's making them do what they do. So it's beneficial to … part of their life.

Sally added the concept of not only knowing that the client was getting good care but also understanding how different conditions might be affecting him or her. This knowledge would be helpful in determination of approaches to use or considerations that were important to care from a social work perspective.

The personal meaning that Karen derived from what she saw of interprofessional collaboration was that she would be able to help people holistically.

> But now we're in here and I see other professionals like you know, doing the same thing – helping – you know? So now that I've taken so many science classes I'm more inclined to a medical degree but, yeah, I wouldn't really mind if I change my mind with one point. You know, social work, hey, you're doing the same thing, you're helping someone and in a much better way, you're listening to people, I love listening to people. So yeah, or listening or trying to help, of course. That's not that social workers just listen, they take action, they help people. That kind of changed when I came to SWITCH…

When she saw what other professions did she understood that she could be a social worker and still be helping others. This insight gave her other options should she not be accepted into a

medical program.

The participants all found satisfaction in knowing that they were helping others. Working interprofessionally had additional benefits. The convenience for the patient was one. Given **Anne**'s story about losing a client between groups, it can be seen that the communication and patient-centredness of interprofessional collaboration would result in more effective service and client centred care would retain the client until the results were achieved. **Sally** and **Sophia** also alluded to convenience, that of knowing other professionals were following up the portions of care that fell within their expertise. The effective communication that was part of interprofessional collaboration facilitated this outcome.

Feeling

Most of the participants had an emotional response to the question about what it means to be working in interprofessional collaboration. **Sophia** said *"It feels great"* and **Sally** said *"it feels good"* and *"It feels comfortable"*. **Coffee** stated *"It's awesome"* and **Karen** enthused *"I love it!"* **Anne** did not specifically describe how interprofessional collaboration felt for her but she did state that the lack of collaboration was frustrating. Anne was also frustrated by the obvious gap in post-secondary education programs that resulted from the omission of teaching interprofessional collaboration. Anne's profession bridged health care and education, demonstrating the need for interprofessional collaboration in other professions as well as in health care.

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The work that I do in my professional practice is intersectoral in nature. Karen alluded to lawyers being involved at SWITCH suggesting that there was also the possibility of intersectoral collaboration at SWITCH. This makes sense to me because all sectors contribute to the health and health conditions of people.

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The findings above came from answers to questions based on selected Heideggerian concepts. The decision to use Heidegger's concepts to guide the interview questions stemmed from a comment of one of my committee members that if I chose a methodology based on this philosopher I should at least read his work. I took the challenge in consideration of theoretical rigour as my committee member had intended, and with the assistance of the writings of others who did the same, I developed my own understanding of some of Heidegger's work.

Findings: A Heideggerian Analysis

The Heideggerian concepts selected to guide the data collection were *Thrownness, Fore-Structure, Clearings, Horizon, Temporality,* and *Modes of Involvement.* The first two concepts related to the stance of the participant developed from birth through relationships and experiences. *Clearings* had to do with shared knowledge, experiences, and values. *Horizon* was evident in the importance of the values and the *Fore-Structure* of the participants. *Horizon* was most easily determined by the frequency with which the participants referred to the ideas. *Temporality* was understood from the part of the timeline of the individual participant's experiences related to the interprofessional collaboration in their past lives and at SWITCH as well as what they saw in their futures. *Modes of Involvement* elicited information about the processes of the participants' work at SWITCH and what happened when it did not go as expected.

Thrownness

While the first inquiry in the interview guide that I developed was based on Heidegger's concept of *Thrownness* (Leonard, 1994), many of the findings related to the concept were refined and added to by the effect of *Fore-Structure* which was based in the whole life experience.

Thrownness was based on the recognition that each person was born into a world with history, culture, knowledge, and language. The *Thrownness* of each participant would have been dissertations of their own. Some of the participants gave more clues related to *Thrownness* than did the others. Of note is **Karen**, who gave a long description of her country of origin and her more recent experience in it. This country had a long experience of turmoil and war since before **Karen** was born. It was still considered a war zone when she last visited it. The question that was asked related to *Thrownness* was an invitation to tell me about themselves. Some included where they were from originally, others did not, likely because these did not see their early life as significant to the project.

Fore-Structure.

The concept of *Fore-Structure* linked understanding with interpretation and represented the cumulative effect of individual's life experience and learning (Plager, 1994). It was difficult to tease out what the individual was thrown into at birth as opposed to what subsequent learning and experiences added to that. *Fore-Structure* has three components. The first is *Fore-Having* which is described as that which is taken for granted about a phenomenon. *Fore-Sight* is what gives us our interest and orientation to the phenomenon. *Fore-Conception* is our understanding of the phenomenon.

Gloria wanted to be a doctor and was encouraged by her father in this regard rather than other professions. Her *Fore-Sight* led her to become a student in Political Studies because she needed a degree before applying for admission to medicine and thought this would be an interesting area to study in preparation for becoming a doctor based on her understanding of what a doctor would be doing to achieve health with others. Her *Fore-Conception* led her to volunteer at SWITCH after hearing a professor talk about the significance of the determinants of

health. The congruency between her *Fore-Conception* of the way health care should be provided and the work that SWITCH was doing kept her volunteering there. She emphasized the effect of the holistic nature and determinants of health throughout her interview. To her, interprofessional collaboration was called for to achieve healthy people. Throughout the interview, Gloria used political concepts and terminology but she was adamant that it was important to achieve health for all people for the public good.

Coffee's familiarity with some of the clients at SWITCH gave her some unease when she was involved in their care due to her *Fore-Conception,* or understanding, that the provision of health care should be confidential in nature. Ethical care was a priority for her and she thought carefully about how to handle that, especially for those that she knew from childhood. Her intimate familiarity with the neighbourhood and its people was part of her heightened sense of ethical behaviour, with an emphasis on conflict of interest and confidentiality.

Sally grew up in a small town and intended to go back there when she graduated from the social work program. She explained the background of community service that she was accustomed to when she was discussing the origin of her commitment to interprofessional collaboration. **Sally** did not notice either egalitarian or collaborative work structures in her hometown and found workplaces in the city to have more of this approach. However, she also stated that it had been a long time since she left her place of origin and thought that the approach to working relationships there may have changed.

Sally recounted that she had travelled extensively in developing countries and had witnessed much poverty but reflected that she was unprepared for the implications of that condition for working with people in Saskatoon's core neighbourhoods. Even though **Sally** had seen poverty her *Fore-Conception* did not prepare her for the experience that the client who was

a drug user gave her by challenging her *Fore-Conceptions*. The challenge of the *Fore-Conception* that of housing being of highest importance, created a profound learning experience for her.

As she reflected on the experience and her reaction to it **Sally** realized that she could not expect everyone to have the same values as she did. Her mentor, by capitalizing on the opportunity for her growth, helped her to see the importance of working with the client's perspective. As **Sally** spoke about this experience she continued to revise her *Fore-Structure* in relation to the poverty, drug use, and shelter perspectives to include a different understanding of drug 'abuse'. If this change in thinking were to continue it would become *Fore-Having*, a process, which if it happened on a much larger scale, could be considered a paradigm shift.

Sophia grew up in an upper middle class neighbourhood of Saskatoon. When I asked her to tell me about herself she stated that she did not need a full program in Arts and Sciences in order to be accepted into Medicine. This fact would indicate that **Sophia** was a very bright student and did well on the entrance exams and interviews. She also stated that she had volunteered at SWITCH from the time she started her university studies, not just since she started in the medical program. In addition **to Gloria** and **Karen, Sophia** had taken advantage of volunteering with SWITCH as preparation for the medical degree.

Sophia felt that because she did nothing to be born into a family with many of the health resources it was important for her to work toward leveling the playing field for those who lacked them through no fault of their own. She also recognized the importance of learning from people with backgrounds and experiences different from hers. This learning would not only increase her knowledge and understanding but would assist her to work more effectively to improve health equity in ways that would be acceptable and meaningful to the clients.

While **Anne** chose to volunteer at SWITCH because she thought it was the most needful area, she had previously been employed in working with women who wanted to have their job readiness skills developed, indicating that this was a theme or *Fore-Sight*. She utilized the research questions to reflect on her past practice, reviewing why some clients were lost from their program, similar to the *Present-to-Hand Mode of Involvement*.

I did not probe for more information about backgrounds because I thought that what they told me was the most significant to them. This conclusion was related to the concept of *Horizon.* Heidegger made a distinction between something that was close to the person and something that was more distant. What was held closely was most important to them; what was held in the distance was not as significant. In retrospect, the participants may have thought that what I wanted was something related to their being at SWITCH.

Knowing their places of origin may not have been useful other than to make generalizations that may not have been accurate. For example, I came from small towns in Northern Alberta, but each one had its own ethos: my 'home' town was full of extended family and people who were close friends of my parents since childhood, including two couples who had their first babies the same day as I, the first for my parents, was born. It was therefore a very safe environment and the close relationships gave constant reinforcement of the townspeople's values. My home town was also considered part of the 'frontier' during the first years of my life. Each small town I lived in was somewhat different, especially the last one which seemed to have several cliques of teenagers my age. My extended family through my marriage lived in a Saskatchewan village with very different values and ways of interacting. From this experience, I could assume that my understanding of 'small town' may be very different from Sally's experience. The full exploration of *Thrownness* with each of these participants would have been

a dissertation in itself.

By the time **Anne**'s interview occurred she had just successfully defended her dissertation and was working as an educational psychologist. She did not give any details as to her origin but she did speak about former roles related to counselling that she had worked in. As she discussed experiences in these roles she reflected on some of the practice issues she had and the implications from those dilemmas. In all of these roles she had worked with vulnerable populations due to her emphasis on being where she was most needed, and was continuing to do so after she completed her PhD.

Each of the participants had unique backgrounds, but there were also similarities, especially in the area of *Fore-Sight*. All of the study participants were volunteering at SWITCH due to their emphasis on helping those who were struggling with health complicated by scant resources compared to the more affluent middle class. Interestingly, while there were male volunteers, none offered to be part of the study, although some showed interest in the research.

Clearings.

Gloria, the first person I interviewed, described the most outstanding common themes for volunteering at SWITCH among these participants: those of the determinants of health and social justice as an approach to evening out the disparities that were symbolized by **Anne** as volunteering where it was really needed, and the holistic view of health. The former related to the deficit in determinants of health for many of the clients of SWITCH. The latter came from a belief, related to the determinants of health model, that health is a holistic state that is influenced by many factors. These two themes were consistent with the values and intents of the Community Clinics in Saskatoon. When the Westside Clinic was moved into a building that was renovated for their needs, their commitment to the concepts and values of SWITCH was shown

by the needs of the work and services provided by SWITC|H being taken into account in the design.

The participants in the current study were connected by *Fore-Structure* in the form of Like-mindedness, related to values about health, social justice, and the amount of practice they needed to be competent practitioners when they graduated. The values that the student organization, SWITCH, was based on were shared with the Community Clinics. There was an understanding in both groups that health care required perspectives and interventions from various professions due to the social determinants needed for optimum health and wellness.

Not surprisingly, all the participants were interested in obtaining more practice in the area of their chosen professions; two were doing this prior to applying for a health profession program to give them a head start in understanding, the rest were working with SWITCH while they were completing the requirements for entering professional practice, partly because of their *Fore-Having* that professionals must be competent, and partly due to the *Fore-Conception* that addressing the deficits in Social Determinants of Health is the answer to the problem of ill-health in the population. While **Anne** was not in an obvious health profession, her role as an educational psychologist was within the determinants of health model due to its preoccupation with mental health and education as determinants of health and she, like the others, chose to work where there was the most need. The two students who were not yet in health sciences programs remained members of the social team but as **Karen** pointed out, still had the opportunity to apply for the shift supervisor positions.

Connectedness.

One significance of the similarities (*Clearings*) between SWITCH and its host

organization, the Westside Community Clinic, was related to the concept of Connectedness studied by Huynh, et al. (2012). Connectedness was defined as

> "a positive emotional sense of wellbeing that results from an individual's strong sense of belonging with other workers and the recipients of one's service. It may manifest itself as a human striving for interpersonal attachments, as well as the need to be connected with one's work and to the values of an organization"

In applying the job demands- resource model in volunteer populations (as cited in Huynh, et al., 2012) Connectedness was found by these researchers to result in higher health, satisfaction, and commitment to continue volunteering with the organization. The match between the chosen careers and the values of both organizations and these student volunteers may have played a critical role in SWITCH's retention of these participants, and their participation in this research.

Another *Clearing* was that all of the participants were university students. One could have assumed that this would be so because SWTICH was a health clinic that was set up for university students to learn and provide health services to the core of Saskatoon where there were many people who lacked the resources of those in the middle and upper middle classes. There were high school students who volunteered on the social team however, none of them offered to participate in the study. I had not anticipated high-school students being interested in the study so had not considered what I would do if one or two volunteered. Including high school students would have raised the risk level of the study and I would have had to obtain appropriate ethics approval to involve them. As the situation never arose it was not an issue.

In summary, there were several *Clearings* that were common ground for the participants,

SWITCH and the host organization, the Westside (Community) Clinic. All of the student participants were taking courses at the university at the time of volunteering for the study, although the two social work students were registered with another university.There was no social work program at the local university at the time of the research. All participants were in education programs related to the determinants of health and were interested in promoting wellness in the core neighbourhoods. The participants all enjoyed volunteering, especially in programs where there was a discrepancy in resources relative to other neighbourhoods in the city. From this perspective, social justice and health equity were foci of their volunteer work. In addition they gained knowledge and experience that would assist and enrich their learning in their respective programs.

Huynh, et al. (2012) found in their research focused on the motivation of volunteers that connectedness was a factor in retaining volunteers: "Connectedness mediates the relationship between job resources and volunteer satisfaction, between job resources and determination to continue, and between job resources and health" (p. 870). Huynh et al. (2012, p. 876) used Huynh's definition of connectedness as:

> A positive emotional sense of well being that results from an individual's strong sense of belonging with other workers and the recipients of one's service. It may manifest itself as a human striving for interpersonal attachments, as well as the need to be connected with one's work and to the values of an organization.

Since the volunteers in this study were not working with the same team members every shift, their commitment to the common values of SHIFT played an important part in their retention in the organization.

Thrownness and *Clearings* highly influenced the F*ore-Structure.* Learning challenged the *Fore-Having*. The difference between my *Fore-Structure* and those of the participants created

some confusion for the participants in understanding 'what I wanted' from them. As students they wanted to give the 'right' answers so were struggling to figure that out. Because '*Being–in-Time*': past, present, and future, is inseparable, all of us as participants have changed in some way due to our interactions and different starting points. An example of this was **Anne** taking the opportunity to reflect on past challenges she had faced in her work and to voice what she thought what the issues were. She was using the present time of the interviews to look at challenges in her past work but was seeing these as coloured by her current understanding as an educational psychologist looking to future work with children, teachers and other staff, as well as parents. The interviews also provoked reflection on the participants' experiences at SWITCH which may have changed the way they understood the events and relationships discussed.

In addition to the differences in the origin of each of the participants, the professional socialization process, knowledge base, and practice competencies would have added diversity in the *Fore-Structures* of each participant. This diversity was a positive aspect in the clinic and the way that the volunteers worked together, produced by the interprofessional nature. For example, when **Coffee** and a medical student assessed a client, the client benefitted from both and a potential problem would have been missed had only one health profession student been present. The medical student may not have seen his admission of respect for the social work student's expertise as an important thing but telling the clinical team that he would not have thought of that significant point was an acknowledgement of how a team of different professions working together can provide better health outcomes. This was an affirmation of the importance of interprofessional collaboration.

The similarities of *Fore-Structure* among the participants provided a *Clearing* of Like-mindedness or common values that facilitated the smooth running and popularity of the clinic.

The common understanding of the determinants of health and the importance of an accepting, holistic approach to providing health care in the core neighbourhoods in addition to the perceived value placed on more clinical learning provided cohesive values for the team. These shared values helped to mitigate the differences in values and approaches of the individual professions represented by the student volunteers. Common values aid understanding each other (Wakerhausen, 2009) and may reduce conflict situations. The fact that there are many values in common does not mean that identities would be blurred because the roles are different. Whitehead (2007) was concerned that interprofessional collaboration would undermine the doctor's leadership role and professional status if the MD was not seen as the ultimate decision maker in patient care. Sophia, the medical student participant, was not of the same attitude.

The *Fore-Structure* of the community clinic itself made the Westside clinic an ideal place for students to learn to collaborate while immersed in the clinical roles of their chosen profession. The cooperative nature of the clinic and the recognition of the need for a multiprofessional staff working collaboratively set an effective stage for the volunteers to learn about what each other had to offer and how to utilize that for the benefit of the clients.

Horizon.

The concept of *Horizon* (MacKey, 2005) is related to the importance that an experience or value has for the individual. *Horizon* is a continuum of space (distance) and *Temporality* of which an experience, or value is held from the individual (Mackey) closer these experiences and values are held to the person the more significant or important they are. I assumed that the experiences and values that the participants discussed first, or in more depth were likely to be more significant. However, there was also the possibility that some things were withheld because they were too personal or too close to the participant. In my interpretation of these concepts

Horizon would have affected the *Fore-Structure* (Leonard, 1994) through emphasizing what was held close over what was distanced (Mackey).

Karen was originally from Asia although she and her family immigrated to Canada when she was quite young. **Karen** was also from a Muslim family which had an effect on how she dressed and presented herself in relation to the other participants who were born and grew up in Canada. As described earlier, she covered her hair but she did this in a non-traditional fashion, by wrapping the scarf around her head and tying it at the back. For me, the headwear had the effect of ambiguity about her culture more than her religion. **Karen** was very firm about her religious beliefs. She stated that strictly in accord with Islam, because God had made people beautiful, beauty should not be hidden yet she chose to cover her hair in public.

The statement about ambiguity is not to say that **Karen** did not have a strong sense of who she was: She knew who she was in the moment but her visit to her country of birth inspired more depth of reflection about what was important to her identity and her understanding of what was religious practice and what was cultural behaviour. She was clear that a woman's covering of herself was cultural and not religious and chose to do so in an unorthodox fashion.

Karen's story demonstrated the fusion of past, present, and future in her *Being-in–the-World*. Even though she and her family left her country of origin when she was an infant she sought out more information and experience there as a young adult. Her identity as a Muslim woman from an Asian country merged with her identity as a young Canadian woman as demonstrated by her choices in covering her hair and the non-traditional head apparel. **Karen** was the only participant who discussed her origins in any detail. It was interesting that while her 'homeland' was at war; she was also excited to hear the experience of a client who, as a young woman, had lived through the Second World War in Europe.

From **Sally**'s comments, it is possible to draw a small conclusion about her *Thrownness*. She was born into a small community that she described as hierarchical as far as work was concerned. She did not see much that she identified as being collaborative in a formal work situation. She also stated that she learned the importance of having a home to live in in her community and struggled with the concept of a client having more significant priorities than conventional shelter. Her *Thrownness* influenced her *Fore-Structure* in that she had difficulty accepting that someone would prefer sleeping outside to going without the drug he used. Because *Thrownness* included the culture and language at our births, it followed that it would provide the initial base for *Fore-Structure.*

Coffee also presented a clue as to some of what she was born into in her community when she stated that she had grown up in the same neighbourhood as SWITCH was located in. This neighbourhood had the highest statistics of all types of crime in the city at the time of data collection (Statistics Canada, 2008). Her research interest in abusive relationships was consistent with her *Thrownness* and *Fore-Structure* obtained from her community of origin. Her choice of social work as a profession gave her the tools with which to address this issue.

For all of the participants, the social determinants of health and social justice were in the foreground. These were also the most discussed concepts among the participants for volunteering at SWITCH. The concepts and the values that accompanied them were common across the professions. As patient-centred care was thought to take the focus off individual professions, these concepts might also play a unifying force as a common goal, by directing efforts toward the needs of the community and the clients.

Temporality.

Anne has already been described as an example of *Temporality* at work. Another

example of *Temporality in Being-in-Time* is **Sally:** what she was taught to value from her childhood influenced her reaction to the client who came into the needle exchange. Her focus was on shelter and safety from the cold and the streets. His need was for safe drug administration. What she had learned to value was taken for granted as something everyone not only wanted, but needed. After her insight that resulted from this incident, she would still likely value shelter for herself but she also gained an understanding of the diversity in priorities of others.

Temporality was a factor in my contributions to the research. Over the time of the research project, my life changed through the addition and loss of family members. My parents moved from the house that was the centre of family activities, I gained a partner, nephew- and niece – in law, a great niece and nephew, and lost a mother and a close cousin and a number of other family members and elderly friends. My father was critically ill but survived, three times, my partner's chronic illness progressed, my sister had a protracted crisis and in spite of my move to a new house my allergies continued, and I was on sick leave. I have read a great deal in relation to this research, which, with the advent of our new curriculum that I participated in developing has become even more relevant to IPC and IPE. What I have learned from this has been very helpful with teaching within a curriculum that is focused on IPE and IPC. These experiences have influenced who I am and how I live and think at this point.

Modes of involvement.

Modes of Involvement were instrumental in the work and relationships of the participants from SWITCH as well as their learning. Most of them had difficulty thinking about the *Unready-to-Hand* mode because most shifts were smooth running (*Ready-to-Hand*). **Anne**'s examples were experiences she had in previous workplaces rather than at SWITCH. She reflected on

clients that never finished their programs and why that may have happened, influenced by her knowledge and experience in the interim, that role, and her new role, and her doctorate education. Questions within the realm of these concepts also elicited descriptions of learning experiences. When there was a breakdown (*Unready–to-hand* Mode) in the usual process (*Ready–to–hand* Mode) of the clinic, the *Unready-to-hand* Mode resulted in the students automatically going into the *Present-to-Hand* Mode by evaluating and reflecting on what happened and how that could be avoided in the future.

The most significant learning described by the participants as epiphanies or eye opening moments, was related to the *Modes of Involvement*. Students learned in all three modes, *Ready-to-Hand, Unready-to-Hand, and Present-to-Hand* but the most profound learning described occurred in the *Present-to-Hand* Mode. Again, *Temporality* merged the past learning with the present and focused the student on the future learning. Part of the decision to volunteer at SWITCH was related to the participants, as university students, wanting to practice their current skills and learn more in their chosen field from the mentors, other students, and their experiences in anticipation of their future needs.

When the clinic was running smoothly (*Ready-to-Hand*) the participants, as student volunteers, learned as planned from the cases they saw, the conduct of other health profession students, their mentors, the community members, and their interactions with others. Their learning was not always related to the work of the clinic; most notable from the data in this category was **Karen** learning what it was like to live during the Second World War from a client who was waiting for her appointment. They also learned from presentations of health care providers, including those who provided services in the alternate or integrated medicine areas, such as acupuncture. Through their time spent in the waiting room, especially on slow shifts,

they also learned about the people of the community through interacting with them as **Karen** did.

The *Unready-to-Hand* Mode acted as a catalyst for learning. Situations in this stage, where smooth running broke down, forced the students into the third Mode that of *Present-to-Hand*, in which they reflected on what had happened and were guided in their learning by other volunteers, especially their mentors. The *Unready-to-Hand* Mode created a 'disconnect' or a 'dissonance' with what they knew or expected, opening the opportunity for epiphanies. This is in keeping with Thomas et al.'s finding of

> cognitive dissonance, or the uncomfortable tension that comes from holding two conflicting thoughts at the same time, is the stimulus for learning. It serves as a driving force that compels the mind to acquire new thoughts or to modify existing beliefs in order to reduce the amount of dissonance (conflict). Cognitive dissonance ultimately determines the organization and nature of what is learned (Thomas et al. (2014).

Coffee's experience in assessing a client with a medical student was an example of mutual learning resulting from the dissonances that rendered the present assumptions *Unready-to-Hand* and provoked reflection on the unexpected. The medical student learned how questions related to a person's social or psychological situation were an important part of health status. His description of this new understanding induced a change in **Coffee**'s concept of the reputation and role of herself as a social work professional. Hovey wrote: "Learning with, from, and about the other can create interprofessional struggles for learners through an experiencing of their own professional identity differently – through new ideas, concepts, and relationships that are outside of their previous educational experiences and understandings" (Hovey, 2011, p. 267). This incident was more of a surprise than a struggle but resulted in a transformation of perspective.

The medical student learned something about the expertise of the social work students

and also about the importance of the possible effects of ‘non-medical’ issues on health. The learning in this instance was mutual when **Coffee** realized she had learned from the medical student how doctors could be appreciative of the knowledge and skills of social workers. This surprised her and provoked reflection on the reputation and significance of the social workers’ roles in health care. In this case there was no struggle, only surprise at insights on both their parts.

CHAPTER V: CONCLUSIONS, DISCUSSION, IMPLICATIONS, REFLECTIONS

In this chapter the major implications for theory, practice and research are identified. Finally my major in-depth reflections on this study and the research process are presented. Right from the first interview 'Like-Mindedness' was a significant theme in the participants' discussions. Engagement of the student volunteers in SWITCH was due in part to like-mindedness. Engagement was significant because it laid a foundation for IPC. Values such as patient centred care and knowledge of and respect for each person's knowledge and skills approach laid a foundation for collaboration.

The recognition of the value that the SWITCH volunteers demonstrated in their interactions with the community members who came into the clinic was one of the reasons cited for the clients' use of the clinic. The volunteers who sat in the waiting room and also offered food and beverages demonstrated the hospitality of SWITCH.

Conclusions and Discussion

Lewin & Reeves (2011) suggested that collaboration improved care, the strongest reason for IPC; however the participants found that the quality of the work and learning kept them coming to volunteer. This collaborative practical experience at SWITCH engaged the volunteers for several reasons, most related to the values, process and structure of the clinic. As Anne stated, it was important to provide comprehensive health care to this population which had several disadvantages due to multiple factors. Also instrumental were *Clearings,* particularly those of similar *Forestructure*. One *Clearing* was that there were common values between the Westside Community Clinic and SWITCH. Another was that the volunteers were valued by the Westside Clinic and the community.

Engagement and connectedness.

Huynh et al. (2012) conducted a study of volunteers based on the concepts of Engagement and Connectedness. They used Schaufeli, et al. (2002) definition of Engagement: "a positive, fulfilling, work-related state of mind that is characterized by vigor, dedication, and absorption" (2002, p.). The themes from the SWITCH volunteers contained evidence that they were engaged in the work of SWITCH. While they did not speak specifically of dedication to the work, Sofia did describe it as addicting. Their identification with the values of the program engaged them in the work of the clinic. The perceived need for more practice than they received in their preparatory programs demonstrated commitment to competent practice in their professions. Once they established relationships with the community through the work of the clinic they felt more connected to the people and to the other volunteers. Vigour for this work would have been necessary in order for them to be full time students in professional programs and volunteer at SWITCH. Some of the participants had other roles with the organization: Anne and Coffee were on the board of SWITCH and Sally and Sophia were employed as Shift Supervisors in addition to volunteering.

Engagement was related to job satisfaction (Huynh et al. 2012). The need for extra practice and fulfilling work was met through the orientations that prepared the volunteers for the work, and the communication structures that kept them informed and feeling involved. Lack of fulfilling involvement was suggested by the study participants as a reason for volunteers dropping out of the program. In their study, Huynh et al. (2012) added a second construct, connectedness, to the test. Connectedness was defined as:

A positive emotional sense of wellbeing results from an individual's strong sense of belonging with other workers and the recipients of one's service. It may manifest itself as a

human striving for interpersonal attachments, as well as the need to be connected with one's work and to the values of an organization in applying the job-demands resource model in volunteer organizations (Huynh et al., 2012, p. 876).

They believed that connectedness was very applicable to volunteers. Connectedness has four components: Other workers, recipients, task requirements and values. Other workers included a sense of belonging and being respected and appreciated. Coffee experienced this facet of connectedness when the medical student described her competence in the client assessment and also when fellow volunteers described their appreciation for her presentation on abusive relationships.

'Recipient' pertained to the relationship with the clients (Hyunh, et al. 2012). When the participants expressed their concerns over quiet shifts it was not unusual for them to fear that the lack of clients was related to them not giving the clients what they valued or needed. They were afraid that what they were doing was not done in an appropriate manner or did not meet their perceived needs.

Task requirements included a connection with the task and the confidence that one can do it well. SWITCH provided this aspect of Cconnectedness for the clinical team by involving the students of the health professions in clinical practice, once they met the criteria of required level in their programs and length of service in the organization. Volunteers also went through orientations to each level of volunteer work and the shift supervisor position when they moved into it, to support competence in the work.

The values component required that the values of the organization, work, and others, paid staff, clients and volunteers were consistent. Common values were included in the characteristic of like-mindedness, a theme in the interviews for the current research project. Coffee identified

the experience of the absence of like-mindedness as a breakdown in the smooth running of the clinic. The common values of all involved were described as a reason for joining SWITCH and for staying. The social justice element of wanting to right the deficits in determinants of health in the community was the common reason for volunteering at SWITCH. There was also a common belief among the participants that due to the lower level of health resources, such as the determinants of health, the best way to provide health services was collaboratively.

Fore-Structure is related to like-mindedness in that values underlie *Fore-Sight* and *Fore-Conception* in particular. There could be significant commonalities among the health professions in *Fore-Sight*, such as the beliefs about the significance of the social determinants of health in the health statistics in different population groups. As described earlier, the *Fore-Conception* of compensation for the inequities in the social determinants of health was believed to be critical to the health of 'disadvantaged' populations. This *Fore-Conception* was a uniting element amongst the participants in spite of the different *Fore-Havings* and *Fore-Sights.* An example of this was the episode between **Coffee** and the medical student. Both the Social Work student and Medical student accepted that the client was in need of assistance: the medical student assumed it was a medical problem because that is what the client described, but **Coffee** also perceived that at least part of the problem could be rooted in a social issue. Because the volunteers assessed the client together and treated each other's expertise with respect the differences in *Fore-Structure* were not only overcome, but resulted in a more relevant approach to her problem.

The identification with SWITCH by the participants was shown by their concern on quiet shifts about why the community members were not utilizing the clinic, even if just for a place to socialize and eat. Collaborative relationships were related to the sense of belonging or responsibility. The understanding of one's role and skills in relation to the rest of the team

boosted **Coffee's** sense of place and competence as team member. These findings would give direction to non-governmental organizations (NGO's) that rely on volunteers to provide their services, however they also are pertinent to collaboration in professional practice.

Facilitators and impediments to interprofessional collaboration.

The chief impediments to interprofessional collaboration have been cited as the well-established hierarchy that is sustained by the health care organizational structures creating and sustaining professional silos and power struggles as well as lack of understanding of each profession's perspective (De Matteo & Reeves, 2013; Engel & Prentice, 2013; Keshet, Ben Ayre & Schiff, 2013). Sommerfeldt, et al. (2011) stated that the type of decisions necessary in health care were not stand alone, but were informed by all pertinent professions involved. SWITCH was organized with the welfare of the community as the central focus.

The processes of the clinic were set up to achieve interprofessional patient centred collaboration and other shared values. This 'like-mindedness' was instrumental in attracting and retaining committed and engaged student volunteers. As could be seen from the findings of this study the clinic did focus on the needs of the community members that used the service. Only when the process broke down for one reason or another did the care falter; for example the child that had an accident in the childcare room, or the mentor who was not carefully vetted before assuming the role on a shift.

Hierarchy as an impediment.

Weinberg, et al. (2011) wrote about the significance of collaborative capacity and stated that the rigidity of the hierarchy in health care organizations made it difficult to move into collaboration as the norm for health care. Currently the most common antidote to the hierarchy and power struggles has been that of a focus on patient centred care: "We find that an emphasis

on PCC [patient centred care] is associated with providers' acting as a collaborative team by promoting greater interdependence, higher quality interactions, and greater provider influence in care decisions." (Weinberg et al., p. 722). With the patient as the central figure of the health care team, team members were thought to be less focused on their own needs and therefore more centred on the needs of the individual patient (Seymour, et al., 2013). Coffee and the medical student with their focus on the client's needs avoided the jurisdictional, hierarchical, and power issues that were referred to by DeMatteo and Reeves (2013).

While SWITCH was set up for IPC, there were still signs of hierarchy or its legacy in the findings but most of those were related to the effort to avoid hierarchical relationships. **Coffee** was surprised when a medical student told the clinical team about her insight and stated he would never have thought of that. Previously she believed that medical students felt that they were above others. This acknowledgement of Coffee's insight and skill by a potential member of the health professions hierarchy had a positive effect on her own identity as a Social Work student as well as her expectations of doctors' attitudes toward her profession. Both **Gloria** and **Sophia** touched on the subject of hierarchy as well and perceived that it was important that people understand that no one profession is better or more prestigious than another. These students of health care professions provided a positive example for the future of interprofessional collaboration in health care.

Patient-centred care.

The process and culture of SWITCH was characterized by a focus on the client's perception of his or her needs first as seen in the vignette of **Coffee** and the medical student. The clients were usually 'examined' by an interprofessional team relevant to the presenting issues and as accepted by the clients. **Coffee** and the medical student were chosen to do the interview

and examination of a client who came to the clinic in need of assistance. **Coffee** 'let' the medical student do his interview first in deference to the client's presentation of a medical problem even though she suspected that it would be rooted in a social situation. The non-clinical volunteers were described as the frontline workers by the clinical team because they were instrumental in developing the person centred relationship. In addition to providing a comprehensive learning experience for the student volunteers the clinic processes and mentors taught the clinical students the skills of interprofessional collaboration by example some of which the social team volunteers would pick up from the debriefing session at the end of the shift.

Another facilitator for IPC was related to **Sally's** statement that working in IPC made her feel more comfortable about the clients when she was not there because she knew there would be another health care professional who was competent to support them if necessary. This sentiment is echoed in Duner's 2013 research findings. She stated that working in teams gave more security to the members in their professional roles because they knew that each one was competent in his or her work that was being carried out and that responsibility did not rest on one person alone. It also required trust in the other's judgments and skills (Duner).

Much has happened and is happening in the literature on interprofessional collaboration and education since the early days of research in this area. Paradis and Reeves summarized the progress (2013). They found through a literature review that the language used for interprofessional work had become more consistent, for example, the choice term 'interprofessional' now appears more consistently but not quite to the exclusion of 'interdisciplinary', multidisciplinary' and 'multiprofessional'. Discussion of hierarchies is waning and the words collaborate and collaboration increasing in use. Interestingly, they also found that the terms patient, care, and caring are used more frequently, a hopeful sign for patient

centred care. More research related to interprofessional collaboration and education is now based in theory and there is an increase in research in the area using methods that support credible and significant findings. The authors also found that the topic of interprofessional collaboration is increasing in high impact journals.

In spite of the above progress toward interprofessional collaboration, barriers to the adoption of interprofessional collaboration have continued to be influential in health care and there have been several positive signs of change in the literature and in practice. Health care professionals have joined with students in clinics like SWITCH to provide patient centred interprofessional care to best serve members of specific communities such as the one SWITCH operates in. One of the most critical factors in the student collaboration at this interprofessional clinic was like-mindedness or shared values that included a strong social justice theme and holistic patient care.

The collaboration of this group of student volunteers was built on respect for each other's knowledge and practice, interprofessional decision making, review of practice experiences, and problem-solving that as role-modeled by mentors. The volunteers cared about each other's experiences as shown by the concern for other's learning and feelings of contribution and belonging to the goals of the organization. Commitment to the common values and the community engaged the volunteers in the clinic. The clinic provided rich learning situations that gave the students the confidence and skills they were looking for. The routine of the shifts and the function of the board were set up to foster interprofessional learning, decision making, and practice. In addition, and perhaps most importantly to the participants, the clients were helped with their health issues. While the participants came into the practice at SWITCH with the understanding of the many faceted aspects of health they added depth to their understandings of

the community and of the process of interprofessional collaboration as well as the benefits through their volunteer work.

Making Sense and Meaning of Interprofessional Collaboration: A Final Comment

This phenomenological research project that was guided by selected concepts of Martin Heidegger to explore the experience and meaning of interprofessional collaboration resulted in several findings. The use of these concepts, especially the concept of *Modes of Involvement,* led to an understanding of the meaning derived from collaborating interprofessionally which included knowing that the patients would be well looked after due to the competence of each member and the diversity of knowledge and skill within the team. They were reassured that no one team member or profession would have the full responsibility for the clients and that together they could make good decisions.

The participants were committed to the work at the SWITCH clinic for several reasons, including the match with their values and future careers, and the desire to help the people of the community make a difference in their health. Interprofessional collaboration was facilitated by the layout of the newly renovated building, in addition to the clinic processes that required and supported an interprofessional approach. The participants described several experiences in which they learned with, from, and about each other, and themselves, as prospective health professionals as they volunteered at SWITCH.

The most “eye opening” learning was described in answer to the question related to the concept of *Unready-to-Hand:* “What is it like when things do not go smoothly?” The dissonance that accompanied the situations described in response demanded resolutions that resulted in learning experiences that stood out above others. In IPE mentors would be able to take advantage of this dissonance by facilitating reflection on the situation resulting on significant

learning experience and, as in the episode with **Sally,** attitude change.

Overall the meaning that they derived from the experience of IPC was the satisfaction, confidence, and reassurance that their clients would be looked after even if they, as individuals, were unable to provide what was needed. They developed the knowledge, skills, attitudes, and experience to give them success in providing patient centred care through interprofessional collaboration in their own practice. These study volunteers and their fellow volunteers now will be able to demonstrate the strengths and strategies of IPC to others, even as novice practitioners. This dissertation was not merely an explication of the research method, rigour and findings but also the use of hermeneutic phenomenology based in Heidegger's philosophy. Hopefully the strategies for rigour provided the transparency necessary to give the reader sufficient understanding of the factors leading to my particular interpretations of the findings of the participants' experience and meaning-making relating to the complexities and challenges of interprofessional collaboration. The student participants in SWITCH have a head start for learning the knowledge, skills and scope of each other's practice.

It has not been an easy journey but I have grown in the understanding of the philosophical underpinnings of this method. That understanding has influenced the interpretation of the findings in a way that likely would not have happened had I not followed the advice to learn about Heidegger's philosophy that underlies the hermeneutic approach.

Implications for Theory

Several of the more significant findings of this study prompt further consideration among communities of researchers, theorists, scholars and those engaged in the teaching, design and planning of IPC processes. These findings are discussed in this section as they pertain to the insights provided for interprofessional collaboration,

Insights into Interprofessional Collaboration (IPC)

In this study The IPC structure and process provided the vehicle for the development of shared norms regarding the critical values of the initiative. Its findings prompt an analytical schema for the impacts of IPC, based upon participant *Understandings, Meanings and* Feelings about IPC experiences. Some of the major impacts of the IPC experience included:

New Understandings of: the distinction between IPC and basic teamwork; focusing expertise on a common goal; the strong emphasis on member inclusivity; a broadening of the concept of 'relevant professionals,' and the primacy of the client; *New meanings about*: self and identity in relation to the role; positive contributions to client care; social justice as a means to even out disparities; the impacts of collaboration and interdependence; subordinating one's own biases, stereotypes and agendas to those of the group; community service; and the value of holistic care; and, *new feelings and appreciations for:* the impact of collective efficacy upon individual efficacy and commitment; a palpable growth in enthusiasm for interprofessional practice; and benefits to be derived from initiatives that broaden the arena of involvement of relevant professions in interprofessional practice.

More broadly, this study introduced some intriguing insights concerning the variety of types of learning generated by the IPC experiences of my participants. There were some rich discussions of experiences relating to the nature of their learning, including: learning from each other, learning from clients and community, learning from mentors (a structured provision built into the initiative), learning from crises and critical incidents, and learning from epiphanies, or what some participants referred to as 'eye-openers.' These were important findings, prompting a

recommendation for further study and theory-building regarding the nature of learning in studies of interprofessional collaboration.

Other findings from this study highlighted insights into IPC relating to its impacts on the enculturation of participants into the core values of the specific initiative (that is, the development of 'like-mindedness' around core values that became shared as members grew into the group structure and processes). The development of a culture of collective introspection and analysis was also commonly referenced in participant discussions of their experiences. These also merit further attention in future IPC research. The above discussion has considerable significance for the processes and content underlying interprofessional learning and interprofessional Practice. It is also pertinent to the theory upon which IPC is based.

Placement of Participants on Benner's (1982) Stages of Growth

To reiterate, the participants in this study were all student volunteers in a student run inner city community clinic. They represented a variety of medical professions and were at various stages of their university preparation for those professions. The location of these participants on Benner's (1982) stages of growth is an important contextual aspect of this study that is worthy of clarification, with the caveat that this placement is based purely upon my knowledge of the participants acquired from the outset of data collection activity at SWITCH.

Benner's Stages of Growth runs through five stages from Novice through Advanced Beginner, Competent and Proficient to Expert. By definition, the participating students in my study would be situated at the lower to middle levels, and their descriptions of their experiences reflected this contextual reality. However, each of the participants had acquired some experience with interprofessional collaboration, though they varied somewhat in the degree of experience attained.

Applying Benner's categories to Participants' stages of growth in interprofessional collaboration, I would place two of them (Gloria, Karen) in the Novice category (beginner with no experience who needs to know general and context-free rules to help perform tasks; exhibits limited and inflexible rule-governed behaviour, and has low self-direction). I would place three of these student participants (Sally, Coffee, Sophia) in the Advanced Beginner category (demonstrates acceptable performance, has gained prior experience in actual situations to recognize recurring meaningful components, and who is beginning to formulate principles to guide actions). I would place one participant (Anne) in the Competent category (having 2-3 years working in the same area, being more aware of long-term goals, planning own actions based upon conscious abstract and analytical thinking). None of these participants would be categorized in the upper (Proficient and Expert) categories.

The Value of a Heideggerian Perspective on 'Being' in IPC

A significant implication of this study for theory is its application of Heidegger's concepts in context: that of interprofessional work among medical students in an inner-city health care unit (SWITCH). The study sheds some light upon the value of Heidegger's concepts in the structuring of the study, and their role in eliciting experiences and related sense-making of participants regarding their experience of interprofessional collaboration. In this study of student experiences, all of Heidegger's concepts were utilized, and they were indeed valuable. However, four of these proved particularly powerful in eliciting and framing student experiences. They are the concepts of *thrownness, clearings temporality*, and *modes of involvement*, and their value in depicting the students' experience of 'being in IPC' is summarized briefly below.

Thrownness

The interviews were structured to allow for up-front discussion the participants' backgrounds: what they brought as persons to the IPC relationship. The use of this concept structured for thoughtful description and reflection among participants, of their culture, knowledge and related assumptions and related biases (that in numerous cases were challenged and re-examined as their experience unfolded). The concept of *thrownness* helped shed light upon the learning experienced by these participants when they went through the process of committing to IPC work, including the development of habits of like-mindedness regarding the core values of the unit. These core values in several cases required a re-examination by participants of their own long-held values, assumptions and biases (their *forestructure*) pertinent to the effective working of the group. The concept of *thrownness* facilitated a rich description and reflection by participants regarding their very different backgrounds. Particularly enlightening was the powerful learning they experienced through sometimes difficult situations and cognitive dissonance that accompanied their experiences at SWITCH.

Clearings

The concept of *clearings* allowed me to elicit the participants' experiences in terms of critical qualities guiding the nature of relationships of the IPC group: the common ground in the motivations and central values guiding their work at SWITCH. Of course there existed common clearings from the outset of the participants' work: the need for practice in their chosen professions, the need to make a difference, the need for relevant IPC experience as a vehicle for entering and succeeding in their chosen professions. This concept facilitated the clarification of the most central values and beliefs guiding the work of the Unit, and the commonalities became increasingly evident over time. In this context, the more prominent guiding values included

social justice, beliefs about holistic care, the centrality of the client, and the subjecting of individual agendas to those of the group.

Temporality

The integration of past, present and future in the participants' reflections helped their process of sense-making regarding the IPC experience. It provided an invaluable means of enriching students' reflections by facilitating the discussion of IPC experiences through emphasis on the relevance of past experience and future plans and goals to current experience: including the current cultural context and the constant varied learning. Often ignored in studies of this nature, the temporality perspective proved a critical source of depth to the accounts.

Modes of Involvement

The concept of *modes of involvement* addressed experiences at the heart of the participants' interprofessional work at SWITCH. In particular, *the present-to-hand* mode of involvement provided valuable direction for interview questions directed at participants' direct experience of interprofessional collaboration. The *ready-to hand* and *unready-to-hand* modes of involvement allowed for insightful accounts of their everyday engagement. Not surprisingly, the participants tended toward a *ready-to-hand* mindset, that is, a common appreciation for the aspects of IPC work that tended to go smoothly, and what it is like to experience a good shift. They talked at length about these experiences, and this gave them supportive aspects to draw from in dealing with the occasional *unready-to-hand* eventualities, when things did not go smoothly. Ironically, it was the *unready-to-hand* experiences that were the occasions for the more transformative learning experiences and 'epiphanies'.

Implications for Research and Further Study

This study employed the hermeneutic phenomenology of Heidegger through interview research methods and qualitative data analysis in order to describe the landscape of its participant's experiences within a common interprofessional context, and to put forth its themes and conclusions. This study was undertaken in a unique context, an inner-city health care unit. Though there is little doubt that individual studies have relevance for IPC generally, a series of studies that examine the experience of interprofessional collaboration across contexts would over time provide invaluable insights into the nature, challenges and impacts of IPC that would inform future practice, research and theory-building. Further, an emerging body of relevant research should inform our understandings of the impact of context upon the dynamics and effectiveness of IPC more generally.

This study also highlights questions about the value of research based upon Heidegger's concepts elucidated in his works, Being in Time and Time and Being. These concepts were central to my development of the interviews and the reporting of participant voices that portrayed their experiences of interprofessional collaboration in the context of an inner city clinic. Without doubt, becoming familiar with the meaning and the complexities of Heiddeger's concepts presented an initial challenge, one that necessitated a commitment to a lengthy process of reading, re-reading and discussion. Those interested in following a similar route should be mindful of this. However, I found the process well worth the aggravation. The use of Heidegger's concepts provided the basis for the design and ordering of the interviews, and for a thoughtful and deep portrayal of the IPC experience across these participants. It allowed for the unfolding of insights into experiences of IPC that were authentic and internally consistent across participants.

It would be valuable to see a series of studies of this topic based upon Heidegger's hermeneutic phenomenology, both for its potential insights into IPC and for its application and elaboration of Heidegger's ideas. Finally, there is a continuing need for a body of studies that would enable future meta-analyses of research on interprofessional collaboration generally. Additionally, IPC research across methodological traditions should help articulate new directions in interprofessional practice in health settings.

Implications for Practice

This was a study about participant experiences of interprofessional collaboration in context: specifically, a student-run clinic in a city's core neighbourhood, a low-income context, where poverty was high, with a culturally mixed community. The emphasis in this clinic was one in which the engagement of patients in their care, and in the planning of community health services was a priority. This study and its findings have considerable value across a variety of individuals, groups and agencies. It revealed valuable insights into how a health care initiative can be operationalised through client participation and user-provider partnership, with the goal of removing barriers to health through innovative engagement and research.

As a study of a student-run clinic this should certainly be of interest to students and faculty in university and college health-care preparation programs, to scholars and researchers with an academic interest in the potential and possibilities of IPC in this context, and across contexts. Given the strong emphasis devoted to community and client participation by SWITCH, the findings of this study should be of considerable interest to communities and community leaders focusing on health care. Further, as a study of student volunteers, it represents an

example of structures and processes by which the expertise and potential of volunteer participants can be successfully tapped.

The study also has implications for mechanisms by which the primary healthcare principles of the World Health Organization (1978) can be realized. Those WHO principles that were exemplified in the unique context of this study included *public participation, inter-sectoral collaboration, accessibility and health promotion.* These principles were reflected in innovative strategies such as the inclusion of a cultural advisor to the SWITCH Council and volunteers, and through the nurturance of norms of accessibility and the maintenance of a respectful, safe environment, about which the participants reflected so vehemently.

Reflections on the Research Process

Once the research proposal was accepted by my committee and ethics approval was received from the University of Saskatchewan I talked with the coordinator of SWITCH about the process for accessing participants from their volunteers. Previously I had presented my plans to the coordinator and the board of SWITCH at which point I thought that it would be best for the coordinator to recruit the participants. Once I had an orientation to this collaborative practice and talked with some of the volunteers I realized that the interest in the study was high enough that volunteers would offer to participate in the study.

Data collection and personal experience

The SWITCH coordinator that I had made arrangements with had just left the organization when I arrived for my orientation to the SWITCH program before recruitment of volunteers started. The volunteer coordinator offered to recruit volunteers for me and arrange a space in the clinic to do the data gathering. I pointed out that the interviews were expected to be an hour or more in length so that this would significantly decrease the work they would do on

their shift. I also did not want to do the interviews on site for fear that it would jeopardize anonymity and confidentiality. Because of the interest the volunteers had shown, I was confident that I would be able to recruit participants myself. When I introduced myself at the Briefing session that initiated each shift, I presented my interest in their experiences as a research project and invited them to approach me to be part of the study.

When the SWITCH volunteer approached me I made arrangements to set up a time and place for her to meet me for an interview. I had not thought about the Social Work students not being covered by the University of Saskatchewan Ethics approval so when the first volunteer came to me and said she was a University of Regina student but was very interested in the research I had to apply to that institution for ethics approval, which was quickly obtained.

In the meantime, I interviewed another SWITCH volunteer, who was an Arts and Sciences student intending to apply to Medicine. This was **Gloria**, whose first interview was not recorded and who graciously volunteered to redo the interview. The solution to this issue is discussed in the section on Rigour. I continued to volunteer at SWITCH to recruit participants and also because I liked working with the people of that community. My enjoyment stemmed from my *Thrownness*: my youth was spent in small northern communities where everyone knew and looked out for each other as many in this neighbourhood do.

I transcribed the first recorded interview myself, however when I realized it was taking me two hours to transcribe fifteen minutes of taped interview I bought a digital recorder and a transcribing machine. I hired a secretary to do the rest of the transcribing. It was a good experience to type the first interview as it gave me the opportunity to see what it was like and where the problems might be. It did not take me long to realize that all the “ums” I read through the first transcript were interruptions to be omitted. I also went back to the recordings when

there were problems with the transcription.

When it came time to analyze the findings I tried to use the questions as a guide for themes, because the questions were based on the Heideggerian concepts I had selected. I found this to be too narrow and fragmented a way to understand the experience. Instead, I read through the transcripts and identified themes within the interview discussions of the participants. The last three categories were asked for specifically to obtain answers to the questions related to the understanding, meaning and feeling about interprofessional collaboration. All the categories were described, rewritten, rearranged, rewritten and rewritten until they captured the understanding and meaning of the experiences.

Personal experience.

My personal experience with the research process was an important part of the methodology because it illuminated the influence of my experiences and thinking on my decisions for the methodology and interpretation of the findings. For this reason it was a significant part of the rigour of the research. As I was writing the Findings Chapter I wrote my reflexions for the analysis into the script in a specific font as I went; the rest were recorded in a reflexions log, a representation of which can be found in this section of this chapter. For the purposes of this chapter, there is no special font for my thinking because it is all my interpretation unless otherwise stated.

I have already discussed my "*Thrownness*" and aspects *of* "*Fore-Structure"* that have influenced my choice of research area in Chapter I. As I got into the research design I found that I had several decisions that needed to be made about the project. Some of these decisions took place as I was writing the proposal for the research. One of the first ones was whether to label the methodology as 'Interpretive' or 'Hermeneutic' Phenomenology. Following is the entry

related to this decision in my Decision log:

> "The terms seem to be used interchangeably in most of the literature, but I associate hermeneutic phenomenology with Max van Manen. I know from my colleagues who have done [or] are doing their PhD's at University of Alberta that he is very particular about his hermeneutic process being followed to the letter. I will probably use a mixture of processes."

At the time of making this decision I was most concerned with the repetitive rewriting aspect due to the fear of never completing the analysis. Two authors that affirmed my decision to label this methodology as Interpretive are Michelle Byrnes (1998) and Tina Koch (1995). Byrne stated:

> The prejudices of the researcher originate from the researcher's historical background. Rather than being an impediment to knowledge making, it is the researcher's values that provide contextual meaning to their consumers. Therefore one research implication of critical hermeneutics is explicating a lens for analysis (1998, p. 7)

I understood this excerpt to mean that while we may each have a different interpretation of an experience, we must be honest with ourselves and our readers about the influences on our understanding. Over my lifetime I have had a myriad of experiences that may colour my beliefs and understanding so it would be dishonest of me to say that I could recall all of the experiences that would influence every specific interpretation. Byrne (1998) also pointed out that Gadamer proposed that "through conversation with the text or with one another an event of understanding will occur that cannot be predicted nor controlled" (p. 8). Heidegger stated: "The question immediately arises to *which* attunement we are to awaken or let become wakeful in us" (2009, p. 89). How do we choose? How can we be sure which if any attunement is the *one* guiding our

interpretation?

When I set out to research this topic, I was adamant that I would use a method other than phenomenology. I felt that having already completed a phenomenological study I needed to use a different methodology. However, my supervisor wisely pointed out that what I wanted to accomplish was phenomenological in nature. I had to agree that he was right and do it or choose a different question. I chose to stay with the question because I believed that interprofessional collaboration had the capacity to produce the quality of care needed in the health care system. I read about the different approaches to phenomenological research and determined that for what I wanted to learn, a hermeneutic approach was most appropriate. Of course, I chose Heidegger as my guide. The experience has been fraught in many ways, not the least of which was my lack of familiarity with the German language and the concepts it entailed. Finding a translation that would be conducive to my understanding was a long process and it was not until I had finished writing the findings that I found a book of Heidegger's work that used a number of translators, edited by one common translator, that I realized I had gained an understanding of his concepts: not a highly sophisticated understanding, but it worked well as a framework to guide my understanding of what the students' experiences and concepts were and what contributed to those understandings and knowledge gained.

At the outset I was adamant that I was not going to do multiple rewrites of the findings, but I found myself writing and rewriting and rewriting as I had time to reflect on each concept in light of the others. Because I continued to work full time during the whole process there were often gaps in time between the individual interviews and the analysis and writing. These breaks in continuity meant that I had to look at what I was doing anew, every time I came back to the work, influenced by the effect of Heidegger's *Temporality.* Koch ((1995) was right: "The

Heideggerian position is that interpreters participate in making data precisely because the hermeneutic circle cannot *be* avoided" (p. 832).

In addition my supervisor's comments and questions led me down different paths as we went. I am grateful to him for reminding me of educational and learning theories that would shed a different light on my conceptualization of the findings. I am more familiar with educational theories within the nursing realm than I am of those within the pedagogy of education. The end result is that this dissertation is based on my learning from the PhD program, literature, the participants, my supervisor, my committee members, countless hours of reflexion and reflection, and my experiences throughout the ensuing time. It will be a work in progress as those who may read it will be making their own interpretations due to their own *Being-In-Time.*

More recently I revisited Tina Koch's article (1995) on interpretive methodologies. She stated that interpreters are part of the generation of knowledge as we go through the process of the hermeneutic circle:

> Co-constitution demands that primary data be regarded as contextualized life events, with the person's and the researcher's perspectives specified, a notion which Gadamer … calls the 'fusion of horizons'. Heidegger broke free from the objectivist ideal which calls for the distinguishing of all the self from the knower in the process of interpretation (p. 882)

This brings me back to my question: "How do I recognize all the experiences in over more than 60 years that are influencing my interpretation? How does anyone do that? I have my supervisor to 'police' these but what about his experiences that influence his agreement or disagreement?"

One of the difficulties of the term 'Hermeneutics' for me was that it was associated with Biblical interpretation. My issue was not with the Bible or with religion; it was that in my world

experience, especially given that I am a member of a "priestly" family, hermeneutics is the interpretation of religious text and secondly, the previous beliefs that all research must be objective therefore in phenomenological research we must bracket. I know from personal experience that the Bible is interpreted in many different ways which may cause conflict and project that onto the multiple interpretations that may come from my findings. Once again I encountered my question about being able to identify, for myself and others, all the influences on my interpretation of any given knowledge or interpretation. I found that Heidegger's concepts of *Clearing* and *Fore-Structure* went some way in calming my fears about bracketing as they took the place of that function.

On February 3, 2009 I logged:

> The Heideggerian terminology/concepts are becoming less scary/more ordinary, but I am still concerned that by using them to guide analysis I will miss the critical understanding of the student experience. Perhaps when they are totally ordinary I won't see them as being superimposed on the student's experience? Is that a good thing? Still not sure of this as a decision.

Gradually these concepts that I chose to guide my interviews became part of my orientation toward the research or perhaps it was guided by that positionality. In retrospect I continued to wonder what I missed by limiting my guiding questions to these concepts. Of course, I did not limit the discussion to the guiding questions, a fact that also created some discomfort with the lack of perfection of the research. In reading the transcripts I thought that I was too 'chatty' in some interviews and in others did not 'dig' deeply enough. In the writing of the dissertation I found that the use of the selected concepts facilitated my understanding, with my biggest coup being the realization that the most profound learning of the participants occurred as a result of dissonant experiences. If I had not used the concepts of *Modes of*

Engagement I may well have missed this altogether.

Later, on the 11th of February 2009, I logged:

> To pilot or not to pilot? What if I go with the first interview – if it is a flop, learn from it and set aside – if it is good, then use it?

I left this decision and the decision about whether to include nursing students as participants in the research unanswered at that time. I waffled on the decision to include nursing students for more time. The issue for me was the risk involved in having participants who I could be evaluating in a required course. In the end, I decided that the risk was too high and because there were very few nursing students volunteering at SWITCH it would not be worth setting up ethical protection in case of involving them. I never met a nursing student volunteer in the time I was collecting data at SWITCH.

At this point there was a long gap in my decision log. There were numerous small decisions involved in writing the proposal, such as whether to follow Benner (1984, 1994) in the use of paradigm cases. I chose not to use paradigm cases because my sample was to be relatively small. One could say that each participant would be a paradigm case. In July I successfully presented and defended my proposal.

There was a significant gap between the acceptance of my proposal and the start of data gathering. My mother's health was failing faster than before and she was facing what for her and my father was a big decision – how long could he, with his own medical problems, continue to look after her? As I, being *the* nurse, was the first on call for medical issues with my parents I was called more frequently. They moved to assisted living in the spring, which turned into a monumental experience for all of us helping them to downsize and move. In October, my teaching partner's mother died unexpectedly so I rescheduled my teaching to give her the time off that she needed. Then I developed H1N1 which kept me quarantined at home for two weeks

and I returned to work earlier than I should have because of my concern for my colleague's grief process. My mother was then diagnosed with a more urgent health problem and I was involved in the discussion of her decision making about the treatment. Less than a week later, in early December my mother died without the dreaded treatment. After Christmas a close family friend died and I took my father to his funeral in British Columbia.

I struggled with my mother's death and grieved for my father's loss as well and it and the H1N1 left me low on the ability to concentrate. In retrospect I should have taken a leave, but I loved the Community Health clinical course that I taught in the core neighbourhoods and did not want to miss it. In addition to this I was on the development committee for our new curriculum due to my involvement in designing our previous (at that time, current) curriculum. Curriculum design was an intense undertaking. A little less than a year after my proposal was accepted I made another key decision related to recruitment of participants:

> I decided to actually go to SWITCH to see if I could recruit students in person. I was reluctant to do this because I was afraid that that could be a bit coercive however, that was how I recruited participants for my master's thesis and it worked well. I went the first time on Saturday, July 10th, 2010 but because I had a family commitment that interfered, by the time I arrived all the students were busy with patients, children, etcetera so I did not have access to them. The volunteer coordinator gave me a tour of SWITCH's new building – it was a big improvement on the previous one - and recommended that I come Wed. at 1700 to participate in the food prep and the opening activities. I did do this and was able to talk a bit about my research (during the introductions).

During that evening another issue that required a decision came up. Throughout the evening I had three students who came to see me about participating, two of whom were very keen. Unfortunately these two were social work students, who, while they took their courses in

Saskatoon, were registered with the University of Regina. I checked to see if University of Saskatchewan ethics approval would cover them but I had to have University of Regina approval. I completed the University of Regina applications and forwarded it to my supervisor for his signature. I did receive permission to interview social work students from the University of Regina and as can be seen from my findings, they were important participants in the study.

In January of 2011 I had all but one of the interviews completed. I had been contemplating how to frame the analysis and started out thinking about a computer program to assist me. My idea was to use the guiding questions as the framework because that would organize the findings consistently with the Heideggerian concepts I had used. I found this to be an artificial and unwieldy process that did little to describe their experiences:

> 01/11/2011
>
> Looking at the dates of my entries my life is flashing by very quickly. So, I am looking at Anne's transcript and am finally starting to see some themes other than the questions. There is a whole theme of how SWITCH, as an interprofessional clinic, works – what makes it successful, what the blips are, and even in Anne's discussion of the blips there is still learning about positive ways to set up and develop interprofessional settings and relationships. Looking at SWITCH and its commitment to interprofessional collaboration in practice and its holistic vision of involving more than the health sciences professions it is easy to see the reasons for its success – the clients/patients feel cared about – the volunteers and employees get to know them and care about what is happening with them. The waiting room is a community that people feel they can belong to and the food and beverage service adds to that social element.

Obviously I had a short memory as I revisited this decision as if for the first time six months later:

> Reflexion: 16 June, 2011

> Just had an 'aha' experience – realized that I was trying to fit my findings into Heidegger's concepts rather than allowing them to speak for themselves – as Pat did. I thought the H. Concepts would give me some insights into the student experience and they still might but best to let the findings speak first. So, now, how can I take a fresh look at this without the overshadowing of those concepts? Is it enough to use them as the interview guide and leave it at that?

I went back to my tried and true system of reading through the transcripts to identify themes. This approach worked much better to describe and discuss their experiences and learning. As Heidegger stated:

> To awaken an attunement means, after all, to let it *become awake* and as such precisely to let it *be*. If, however, we make an attunement conscious – come to know of it and explicitly make the attunement itself into an object of knowledge – we achieve the contrary of an awakening. The attunement is thereby precisely destroyed, or at least not intensified but weakened and altered (Heidegger, 2009, p. 82).

I started writing as I went through the transcripts again and repeated the process.

There were times when I had difficulty seeing beyond what I had done previously and then there were my own 'Aha!' moments. There were often times when I was too busy with work as when I was assigned an additional course for a colleague who was being treated for cancer; and in the summer of 2012 I moved and had several family issues as I was in emergency with either my father or my partner throughout. I lost an aunt and uncle and two cousins, one of whom was married to my lifelong best friend. I took time away to be with her through her husband's dying.

Each time there was a break in my attention to the findings and the literature, I had to review what I had done when I got back to working on Chapter IV. While these episodes slowed me down, they were useful in that they temporarily distanced me from the findings. It enabled

me to take a fresher look at what I had done and what the findings really were telling me. I was forced into the Hermeneutic Circle whether I wanted to do it or not.

> 26 July, 2013:
>
> Yesterday I read two articles that I am puzzled about how to use, both of which I found through use of the search term 'connectedness'. The first, by Shakun (2013) was based in game decision making research. The author emphasized that group decision making should include morality and spirituality. Today, on the front page of the local paper the primary story was of a nursing home resident who died and the moral decision that was made in how to break the news to the family (Warick, J., 2013, p. 1). The woman died due to asphyxiation when she was caught between the side rail and the mattress with her body partially on the mattress, dangling, and on the floor. The woman was moved back into her bed to look like she had a peaceful death. Whether the decision to move her and withhold the details of her death was made primarily to ease the distress of the family or to avoid criticism for her care and a possible court case is not discussed in the newspaper but neither of these goals was realized. This event highlights the moral and spiritual aspects of health care decision making be it uniprofessional, multiprofessional or interprofessional" (from Reflexions,). Sally's experience with the client who was a drug user was one of those experiences when we are confronted by a difference in opinion of what is a proper lifestyle.
>
> The second article was a discussion about using a more metaphysical approach to teaching medicine. The author, Bruce Wilson (2013), was concerned that medical professionals were taught to esteem only proven facts. Wilson suggested that the concept of holism in health in conjunction with reflective practice would bring the concept of connectedness into medicine. Wilson used the social determinants of health as an example of connectedness in health. Reflexion on this incident assisted me to articulate the significance of these two

articles for Interprofessional Education and Collaboration. A discussion of the importance of a different facet of connectedness used in the Job Satisfaction literature and applied to this interprofessional collaborative practice can be found further in this chapter.

Both these authors (Shakun, 2013 & Wilson, 2013) were emphasizing the need to make decisions based on the whole picture taking into account the moral and spiritual aspects of the situation. The recent news story referred to above gave strength to the need to prepare students of the health professions and existing professionals for decision making that includes moral and spiritual components in addition to scientific knowledge and ethics. Ethical practice is required for health care professionals (Canadian Association of Occupational Therapists 2007; Canadian Association of Social Workers, 2005; Canadian Association of Speech-Language Pathologists and Audiologists, 2011; Canadian Council of Practical Nursing Group, 2013; Canadian Dental Hygienists Association, 2012; Canadian Medical Association, 2004; Canadian Nurses Association, 2008; & Canadian Physiotherapy Association, 2011) because of our connectedness with and influence of others.

Sally's experience with the client who valued illicit drugs over shelter was another example of the need for moral and spiritual expertise in decision making. Wilson's (2013) belief that reflective practice would lead medical students to an understanding of the holistic and complex nature of health could be augmented and reinforced by a strong emphasis on interprofessional education. The attention to multiple components of life and health that would be brought to learning and practice through a variety of professions would assist with more holistic reflection guiding practice decisions. Sally's mentor guided her reflection on the incident. Coffee's experience with the medical student and client who had a social component to health status supported the need for a holistic approach and interprofessional practice for

students of the health professions.

> From my career as a professor in the University of Saskatchewan College of Nursing in which I have taught students in clinical situated in a community low in health determinants but rich in relationships and resourcefulness, I have often regretted that we do not do well in teaching the students how to assess and deal with the spiritual needs of our clients. Fortunately the students aptly demonstrated the basic skills and to affirm the knowledge, skills, and worth of the community members. Those skills came automatically from a patient centred focus.

Could it be that at least part of what kept the volunteers at SWITCH was the connection with people for whom they were providing a moral service in righting the disparity of health for those who are less privileged in addition to living out their values of equity? In my work in the same neighbourhood I have found the people to be remarkably genuine and open. They are kind to each other and in many cases look after those that they perceive to be less able or fortunate than them. I have found that the moral issues engage the students in reflection and discussion. There were always students, that like **Sally**, struggled with the moral issues that many people who lived in poverty dealt with such as: should a single mother have chosen to stay on social assistance to be available to her children rather than go to work and leave them on their own; or were needle exchanges morally wrong because it suggested that using illicit drugs was acceptable. Like the moments of dissonance that the participants in this study experienced, these questions provoked an uncomfortable conflict between what should have been and what was.

> October 9, 2013:
> When Chapter V was almost complete, I was asked by a committee member what the essence of interprofessional collaboration was. My answer was that I was not looking for essences because this research was oriented toward interpretation of

> the participants' experiences. On reflection today, I realized that the one very consistent and grounding theme among the participants was Patient Centred Care although it was not identified as such by them, but their stories and values indicated a devotion to holistic, patient centred care. Patient Centred Care was addressed earlier in the dissertation. This Fore-conception was based in the model of the Determinants of Health and the value placed on holistic approaches to health care. Sally's statement about sleeping better at night knowing there were others to look after the patient indicated the focus of her concern on the patient.

More light could be shed on **Sally's** comment above by the findings of Duner (2013) who, in her study on teamwork and professional boundaries in Elderly care in Sweden, found that: "Working together in a team with other professions can lead to more security in one's professional role, when one sees the competence of the other team members and can concentrate on one's own expert knowledge" (p. 250). Understanding that there were others to share a related but different set of knowledge brought the security of having a broader knowledge base without needing to know everything. Duner also pointed out that the members of the team appreciated that their own knowledge deepened from working with other health professionals.

The above reflexions were an integral part of rigour in a qualitative study. They assisted the reader to determine at least some of the influence that my *Fore-Structure* had on the selection of research questions, interview questions and discussion, in addition to the interpretation of the findings.

Retrospective on rigour.

As I discussed in Chapter III if research findings are to be considered credible and applicable to the phenomenon they must meet the criteria of an evaluation of rigour. The positivist assessment criteria of validity, reliability, and generalizability are not relevant

measures to determine the value of qualitative research: "Instead, terms such as *rigour* (thoroughness and appropriateness of the use of research methods), *credibility* (meaningful, well presented findings) and *relevance* (utility of findings) are used to judge the quality" (Kitto et al., 2008, p. 243). The methods for rigour chosen for this study were based upon Theoretical, Procedural, Interpretive, and Evaluative criteria (See Chapter III) with a view to determining insights from the process. My reflexions on each of these in retrospect are presented below.

Theoretical Rigour.

As discussed in Chapter III, theoretical rigour was maintained by ensuring that the method fit the purpose and questions of the research project. The purpose and questions of this study were based in experience and meaning making therefore an interpretive or hermeneutic approach was required. While the interview questions were based in select Heideggerian concepts, the interviews were openly exploratory, aimed at understanding the experiences of and meaning made from, the participants' experiences of volunteer work with an interprofessional collaborative student run clinic.

All the concepts that I chose were related to *Being-in-the-World*. Because *Being-in-the-World* is *Temporal* there is a continuum of each participant's past, present and future making up the 'now' in the reasons for volunteering at SWITCH, the experiences they chose to discuss and the interpretations of these experiences. The decision to discuss concepts discretely created artificial distinctions in the interpretation of the findings but they came together in *Being–in–Time.*

The questions were mostly open-ended and clarification and depth were sought throughout. The interviews, with the exception of the first one, were recorded, transcribed, read, and reread. I could not predict exactly what I would find so in addition to the question guide, I

used the last two interviews to probe more deeply into the aspects of collaboration that were revealed in the previous discussions.

The hermeneutic circle was the strategy used for interpreting the findings. It was important for both the reader and me to see the influence of my *Thrownness* and *Fore-Structure* in the interpretation of the findings. Gadamer did not see this as problematic:

> philosophical hermeneutics concludes that understanding is in fact only possible when one brings one's own presuppositions into play! The productive contribution of the interpreter belongs in an indispensable [*unaufhebbare*] way to the meaning of understanding itself. … Certainly philosophical hermeneutics does not legitimize private and arbitrary subjective biases and prejudices, because for it the sole measure which it allows is the 'matter' [*Sache*] being considered at the time, or the text one is seeking to understand. (Gadamer, 2006, p. 45).

From the point at which I started the interpretation of the findings I wrote most of my related reflexions directly into the chapter rather than keeping them in a separate file. This enabled the reader and me to see the influences of my experiences and understanding on the interpretation of the participants' understanding.

The participants also reflected on their experiences and the learning from them as they responded to my questions. At times my *Fore-Structure* blocked their meanings and it was not until I considered their responses in the context of their whole interview and what other participants expressed, that I gained an understanding beyond my assumptions. As much as I balked at the routine of writing, reflecting, writing… I came to appreciate the real significance of the process:

> one who understands does not claim to hold a superior position in advance but instead admits that his or her own assumed truth must be put to the test in the act of understanding. This moment is included in all understanding, and for this reason every understanding of something contributes to the further development of the

> effective historical consciousness [and thus to further self-knowledge] (Gadamer, 2006, p. 51).

Gadamer believed that to have understanding one must have presuppositions about the experience first, but that as a person critiques someone else's understanding so must he or she examine him- or her- self. This reflexion happened automatically as I wrote, reflected and rewrote.

Procedural rigour.

The main strategy for procedural rigour is transparency throughout the research. My interest in students and interprofessional practice is well documented in Chapter I. In a qualitative research course, the first course I took in preparation for the PhD program, I wrote a paper on Reflexion as a part of the method in qualitative research. This paper formed the basis for identifying and clarifying the reasons for my interest in Interprofessional Collaboration and health sciences students in the research proposal. Major decisions in designing and carrying out the research were recorded in a Decision log, some of which are recorded in the Personal Experience portion of Chapter V.

There were two changes from the original proposal that were made near the beginning of the study. The first was the decision to obtain participants by introducing myself and the study at the introduction and briefing session at the beginning of each shift. At this time I invited anyone who was interested in the study to talk with me during or at the end of the shift. During each shift I talked with several of the volunteers so that a student volunteer speaking with me would not necessarily indicate that he or she was volunteering to participate. The only disadvantage of this strategy was that due to confidentiality for the clients, I could not take part on the clinical team. Members of the clinical team remained in a private area where the social team did not usually go. I was able to meet the clinical team members at the briefing and debriefing sessions.

In addition to these times, the clinical team members usually assisted with food preparation, which I participated in, until the briefing session started.

The second change that I made was that I only did one interview per participant. The interviews proved to be in-depth and rich in data due to the reflective ability of the participants who volunteered. While there were differences among the participants, they were most distinguished by their like-mindedness (*Fore-Conception).*

Various paper versions of the Findings chapter were kept. Most of the changes were related to wording and organization in addition to clarification and fleshing out of the concepts. The paper trail also recorded the input of my supervisor throughout the writing. In addition all of the recordings and transcripts are still available for reference. While I was writing Chapter IV I went back and forth between the transcripts and writing. When I found something in the transcript that puzzled me I listened to the recording of the interview to clarify what was said and listened to the voice for added clues. Throughout Chapter IV I have used quotes from the participants as examples of the concepts and themes. The voices of the participants were the core of the dissertation and were recorded liberally throughout. My reflexive voice as a participant was included because it was important that the reader have access to my input into the findings.

The participants provided a rich array of concepts and experiences from which to learn about the student experience in interprofessional collaboration. They did this respectfully, enthusiastically, and thoughtfully. Their dedication to being the best health professionals they could be for the community they served was evident in every interview. Their caring about the community members was a constant theme and their commitment to the ideal of interprofessional collaboration led them to volunteer for the research project.

Interpretive rigour.

Interpretive rigour also included transparency and richness in the participants' voices as well as my voice so that the contributions of all participants could be seen. Themes emerged from the interviews quickly and some were reinforced by subsequent interviews and others were enlarged upon through added details. It was exciting to see the concepts grow in detail and depth from interview to interview. After interviewing the sixth participant I felt that no new themes were arising although each participant had a different experience. The sense of growth in knowledge and understanding through practicing at SWITCH was consistent for all participants except Anne, who based much of her interview in prior and current workplaces. Anne was unusual in that while I was collecting data she graduated and started a new position consistent with her educational attainment.

Evaluative rigour.

Evaluative Rigour is related to maintaining the ethics for the research. Ethics approval was received from both the University of Saskatchewan and the University of Regina and extended until the data collection was completed. SWITCH and the Community Clinics were willing to have the research carried out through their facilities. The research project was deemed low risk because I chose not to involve students that I had taught or would teach in the future. This decision was also related to justice and inclusiveness in that a significant group was excluded from the study; however there were very few nursing students active in SWITCH at the time and by the end of data collection I had not come into contact with a nursing student at SWITCH. It seemed reasonable to exclude these students due to the increased risk for them from my position at the university.

I vacillated on this decision because of the risk versus the lack of inclusion for the group.

I spoke with a colleague who included our nursing students in several studies and she recommended that I include them to avoid the harm of exclusion. The courses I taught were co-taught so I could have arranged to have the co-teacher mark their work however that would mean identification of these participants. As it happened I did not have contact with nursing students volunteering at SWITCH so none were excluded and the dilemma was avoided.

Prospective participants were given information about the research and contact information for questions or concerns about the research and its conduct. Participants took part in the research voluntarily by contacting me and their consent was obtained for the interviews. Anonymity was maintained through use of code names. At the beginning of the interviews the participants were invited to select their own code names which were then used throughout the whole research process. This strategy was so effective that the code name became the participant for me. I and my supervisor were the only participants that could be identified by our real names. The participants were assured that they could withdraw at any time from the research without any undue consequences, both verbally and in writing. There was no deception in any component of the research. The interviews were conducted in my office in the College of Nursing so, even if I had not disclosed that I was a professor in nursing as well as a graduate student, the participants would have learned my additional role at the university.

Balancing harm and benefit is an interesting concern for qualitative research. As long as the ethical strategies were employed universally, the only harm that I could identify was that at some point in the interview the participant might experience distress from recalling an uncomfortable situation. The participants did discuss situations that had concerned them but their reflections on these situations usually ended with the disclosure of a significant learning experience.

The procedures for rigour and ethics were an integral part of the methodology and worked well throughout the data collection. It was helpful that each of the participants approached me about being part of the research. Their initiative in coming to me demonstrated their commitment to interprofessional collaboration and their interest in participating. It was also heartening to see students wanting to participate in knowledge generation.

Given that the interview questions were guided by selected Heideggerian concepts of *Thrownness, Fore-Structure, Clearing, Temporality Horizon,* and *Modes of Involvement,* this interpretation was influenced by *my* understanding of those concepts. I did struggle with understanding Heidegger's work, On Time and Being (1972) but by the time I was reading his work, Being and Time (2010) the understanding had become easier. I also read works by Benner (2004), Byrne, 1998), Fjelland, (2004), Koch (1995), Leonard (2004), and Plager (1994) in order to develop the proposal for this research. These researchers also based their research on Heidegger's concepts influenced by Hubert Drefus' interpretations. Patricia Benner being a nurse scholar was helpful to my understanding of the concepts.

During the time of writing the dissertation after the proposal stage I continued to go back to the literature. More recently I read more translations of Heidegger's work in a book of selected writings edited by Figal (2009). I found this translation to be easier to understand his reasoning than Time and Being (1972/2002) and Being and Time (Heidegger, 2010) to be more relevant to the concepts I used. In addition to Heidegger's concepts, the current literature in relevant areas was considered to produce a more robust conceptualization of the experience of these students of the health professions in a collaborative student run primary care practice. It seemed impossible to separate the information that the participants volunteered into strict categories of the Heideggerian concepts chosen to guide the questions.

Last thoughts on the research findings and IPE/IPC

Originally each profession sought to socialize their students to the values and attitudes of their members. To be successful, IPC will require a common addition to the socialization of all health care profession students to incorporate knowledge of and respect for the knowledge, values, and skills of each of the professions as a basis for the provision of optimum health care and respect for the patient as the focus of their care. Interprofessional learning is another aspect of IPC that will continue throughout careers, perhaps as a response to dissonance and the perceived need for resolution. As Makowski & Epstein state that when dissonance occurs we should "lean into it" (2012, p.298). In reflecting on the dissonance the participants learned valuable lessons from the experience.

This phenomenological research project was guided by selected concepts of Martin Heidegger to explore the experience and meaning of interprofessional collaboration. The use of these concepts, especially the concept of *Modes of Involvement*, led to an understanding of the meaning derived from collaborating interprofessionally which included knowing that the patients would be well looked after due to the competence of each member and the diversity of knowledge and skill within the team. They were reassured that no one team member or profession would have the full responsibility for the clients and that tog This dissertation was not merely an explication of the research method, rigour and findings but also the use of hermeneutic phenomenology based on Heidegger's philosophy.

It has not been an easy journey but I have grown in the understanding of the philosophical underpinnings of the method. That understanding has influenced the interpretation of the findings in a way that likely would not have happened had I not followed the advice to learn about Heidegger's philosophy that underlies the hermeneutic approach. Hopefully the

strategies for rigour provided the transparency necessary to give the reader sufficient understanding of the factors leading to my particular interpretations of the participants' experience and meaning-making relating to the complexities and challenges of interprofessional collaboration.

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APPENDIX A

GUIDING INTERVIEW QUESTIONS

1. Tell me a bit about yourself (Thrownness, Clearings)
2. What attracted you to SWITCH? (Fore-Sight)
3. What did you know about interprofessional practice before you started at SWITCH? (Fore-Having, Having-Been)

Probe:

Any interprofessional experiences? What were they like? What did you "take home" from these?

4. What, if anything from your past experience/learning contributes to your interprofessional collaboration?
5. What is it like for you to be practicing with other professions? (Being; may stimulate Present-to-Hand mode of engagement)
6. How do you/they work as a team?
7. What makes SWITCH successful?
8. What is your experience like when everything runs smoothly in interprofessional practice? (Ready-to-Hand Mode of Engagement) *i.e. when you have a good shift?*

   Probe:
9. Tell me about a time when everything you were involved in in interprofessional practice ran smoothly? What made it smooth?
10. What is it like when things don't go smoothly? (Unready-to-Hand Mode of Engagement – may stimulate Present-to-Hand) *or you don't have a good shift?*

Probe: what happened/was going on? How did you feel?

11. What is your understanding of interprofessional practice/collaboration now? What does it mean to you? How does it feel?

APPENDIX B

Heideggerian Concepts

Thrownness

We enter life in an already meaningful context: culture, family, language…

Clearing

The space we are in, in which we share specific knowledge, experience, culture, values…

Temporality

Being-in-Time: the present cannot be separated from past and future

Having-Been (past)

Being (present)

Being-Expectant (future)

Modes of Involvement aka intentionality

Situate engagement of participants in everyday activities and their interpretation

Ready-to-Hand: Things function smoothly – not much conscious awareness of how they are going.

Unready-to-Hand: There is a breakdown in how things function – now the activity is in the foreground of our consciousness

Present-to-Hand: we step back to reflect, theorize, experiment, study…

Fore-Structure

Links understanding with interpretation

Fore-Having: What is taken-for-granted about the phenomenon

Fore-Sight: Our orientation toward the phenomenon – eg. What gives us our interest in the phenomenon – or not.

Fore-Conception: our understanding – eg. What counts as a question about the phenomenon; what counts as an answer

Horizon

Temporality + Space

Spatial Horizon: Foreground or what the person holds closest to him/herself:

Background – what the person keeps in the distance

This distinction is critical to interpreting meaning

APPENDIX C

ETHICS

Behavioural Research Ethics Board (Beh-REB)

APPLICATION FOR APPROVAL OF RESEARCH PROTOCOL

1. **Name of researcher**

   Dr. Patrick Renihan Supervisor, Educational Administration

   Name of student

   Katherine Ash Ph.D. Study, Educational Administration

1b. Anticipated start date of the research study (phase) and the expected completion date of the study (phase).

Anticipated Start Date:	August, 2009
Anticipated Completion Date:	September, 2009

2. Title of Study

A Phenomenological Exploration of Students Experience of Interprofessional Practice

3. Abstract (100-250 words)

The purpose of this research is to gain understanding of experiences of the relationships of health profession students in a context of an interprofessional clinical practice. The questions that will guide the study are:

What are the students' experiences in forming and working in interprofessional relationships?

What sense do the students make of these experiences and relationships?

A hermeneutic phenomenological approach will be used to explore the students' past and current experiences and sense making of interprofessional relationships in this practice. Heideggerian concepts such as Fore-Structure (Plager, 1994) and temporality (MacKey, 2005) will ensure that the contexts of the data and analysis are clear. The data will be collected through interviews with University of Saskatchewan students volunteering in the student run Student Wellness Initiative Toward Community Health (SWITCH). Interviews will be unstructured in nature in order to allow depth and richness of description. The Hermeneutic circle of moving back and forth between the participant, the text generated from the interviews, and the analysis will capture the student experience (Rapport& Wainwright, 2006). The understanding derived from this study will inform the design of future interprofessional education for health science students.

4. Funding

This study will be self-funded.

5. Conflict of Interest

There is no anticipated conflict of interest in this study.

6. Participants

Recruitment of participants will be through raising awareness of the opportunity to participate in this study by posters in the clinic that the SWITCH volunteers practice in. If this is not successful the program coordinator has offered to recruit volunteers for me. Criteria for participation include experience as a health profession student SWITCH volunteer, willingness to be involved, being able to articulate and critically examine experience, and having the time to spend in the interviews.

7. Recruitment

The poster for recruitment may be found in Appendix

The letter of invitation may be found in Appendix

8. Consent

The consent form is included in Appendix B

Recruitment from organizations

Although SWITCH operates out of the Westside Clinic, data gathering will not involve clinic employees or clients. The volunteers will be recruited solely as SWITCH student volunteers therefore will not require approval from the Community Clinic/Westside Clinic.

9. Methods/Procedures

Hermeneutic phenomenology requires a non-formatted data gathering approach to discover what is important to the participant about the phenomenon and the meaning that this has for the individual. A sample of questions that may be used to guide the interview if more direction is needed is attached as Appendix A. The basic interview process will begin with me introducing myself and establishing rapport. An opportunity will be given for the participant to clarify the information about the study after which I will ask if it is still a project that the participant is willing to be part of.

The basic format for the data collection for each individual will be two interviews. The first interview will consist of questions asked to obtain information of the participant's experience in interprofessional practice, including any outside of SWITCH. The information from outside of SWITCH will clarify the student's context or *fore-structure*. At the end of this interview I will ask if the student is still willing to do a second interview. After the interview has been transcribed and I have listened to the tape for vocal expression and read and reflected on the transcript I will interview the participant again, if he or she is willing, to fill in gaps in information, clarify things that I am not sure that I understand, and ask for feedback on my interpretation and analysis to that point. At the end of this interview I will ask if the student would be willing to participate in a third interview, when I have analyzed the data from two or more other participants, to clarify emerging themes in terms of his or her experiences.

10. Storage of Data

Once the dissertation is completed, data will be securely stored for five years in a locked cabinet in the office of my Ph.D. supervisor, Pat Renihan: Room 3073 Education. This data will include tapes, transcripts, interview notes, reflexions, decision log and any other information

pertaining to the data that I may have recorded in writing.

11. Dissemination of Results

The results of this study may be disseminated through scientific paper presentations, other invited presentations, published papers or chapters in books, in my teaching or in my professional practice (health and wellness promotion and programming for marginalized people, particularly older adults), as well as in my dissertation.

12. Risk, Benefits, and Deception

a) The only potential risk is a threat to confidentiality due to the nature of disseminating the findings of qualitative research. Writing up the results involves using quotes from the participants to illustrate points in the discussion. Care will be taken to use pseudonyms for any potentially identifying information such as names, places and programs. Anonymity will not be comprised due to the high number of volunteers in SWITCH compared to the three to six participants required for this study. Audio tapes will be kept secure and not used in dissemination of the findings of the study.

b) Benefits of the study will stem from the dissemination of the findings to inform future interprofessional educational programming. While these participants will likely not benefit from the findings in their roles as students they may experience improvements in interprofessional collaboration as practitioners when future graduates become their colleagues. Interprofessional collaboration is thought to increase quality of care so that more effective interprofessional relations may improve quality of care.

13. Confidentiality

Each participant will be offered the opportunity to choose a pseudonym or to have me select one for him or her. This pseudonym will be used comprehensively throughout the transcripts, dissertation and any dissemination of the findings. There will be no recorded connection between participant name and pseudonym except for a list that will be kept securely and destroyed when the dissertation is completed. This list is important to keep the data from each participant in context. Pseudonyms for people, places, and programs will be used consistently throughout the data, and research dissemination media, including direct, written quotations. Information gathered about the participants will be limited to that which is related to interprofessional contexts and experience, as defined by Heideggerian concepts such as fore-structure, temporality, and involvement.

12. Data/Transcript Release

Participants will not be asked to review their transcripts, however, if a participant requests to review his or her transcripts the request will be granted. If a participant wishes to withdraw statements with or without reviewing the transcripts, that request will be honoured. Participants will be made aware of this option when the study information is explained before they sign the consent forms. The consent form will clearly state that direct quotes will be used in the dissertation and subsequent dissemination of the findings. Several researchers using phenomenological methodologies recommend not having the transcripts reviewed because they have found that transcript reviews shift the emphasis to details of word choice, from the overall understanding and meaning of the concepts. Instead they recommend having the participants respond to the researcher's interpretation during the second, or, if included, third, interviews.

Cohen and Crabtree (2008) related such forms of member checks to realism rather than interpretivism and state that transcript reviews by participants are not part of the rigour of interpretive research such as hermeneutic phenomenology. Kitto, Chesters & Grbich (2008) state that the time interval between the interview and the transcript review can lead to evolution of perceptions. These authors find that the critical factor is how well the researcher's portrayal of their experiences fits with their perceptions. Interpretive research, such as that guided by this methodology is accepted as co-created among participants and researcher (Lowes & Prowse, 2001).

15. Debriefing and feedback

Participants will be sent a summary of the findings if they request it and leave appropriate contact information. If a participant would like to discuss any part of his or her participation in the study I will do so upon request. The participant may contact me through the contact information on the letter of invitation or the consent form if he or she wishes to discuss issues arising from the interview.

16. <u>Required Signatures</u>

Student _____

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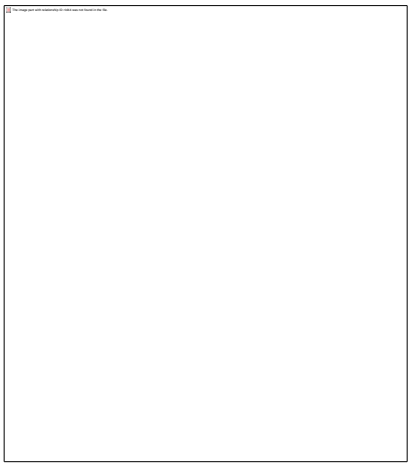
Appendix D

Recruitment Poster and Invitation to Participate

You are invited to participate in a study on

Students in Interprofessional Practice



A Phenomenological Exploration of Students Experience of Interprofessional Practice

I am interested in your experiences of interprofessional practice in a student-run clinic. I would like to hear what it is like for you to work in relationships with other health profession students in a health care setting.

The findings of this study will contribute to the knowledge of student's practice relationship as a part of the understanding of how interprofessional student experiences should be designed.

If you are interested please contact me for more information

Katherine Ash Ph.D.(c)
966-6243
Katherine.ash@usask.ca

Invitation to Participate in the Study
A Phenomenological Exploration of Student Experiences in Interprofessional Practice

You are invited to participate in this study about the student experiences of relationships in an interprofessional practice. While there is enthusiasm about interprofessional education, little is known about the student experience of interprofessional relationships. Knowledge about how students experience and understand these relationships is important to designing interprofessional courses and projects that will contribute to the development of effective interprofessional collaboration in practice.

The methodology for this study is an interpretive one based in hermeneutic phenomenology. This qualitative methodology will involve two unstructured interviews of about 1 hour each. The interviews will be audiotaped and transcripts of these will be typed. There is no requirement for you to review the transcripts but you have the option of doing so if you wish. The first interview will be focused on gaining a description of your experiences and understanding of working in interprofessional practice relationships. The second interview will consist of clarification of specific points or concepts arising from your first interview, as well as consideration of the appropriateness of my understanding and interpretation of the information you have provided. You will also have the opportunity to enlarge on and add to what you said in the first interview.

The data analysis will follow the hermeneutic circle of interviewing (interview #1), reflecting on the information, going back to the participant for more details and clarification (interview #2) reflecting and identifying themes, writing, and if necessary asking for a third interview to have feedback on my interpretation. Quotes from the interviews will be used in the discussion of the findings to substantiate the concepts arising.

This study has approval of the Behavioural Research Ethics Board of the University of Saskatchewan. There will be no penalty for not participating or for withdrawing from the study at any time. You may withdraw statements from the study before the dissertation is written. Although you have signed the consent form I will ask for verbal consent before each interview is set up. Your privacy will be protected by use of pseudonyms (code names) and by omitting your name on any tapes or documents. Great care will be taken to provide no identification of participants through contextual description or through the quotes used.

The results of this study will be published as scientific papers as well as being the substance of my dissertation. I will also present papers discussing this research at conferences and incorporate it into my teaching and professional practice.

Your request for a copy of your transcripts and a summary of the study will be honoured and you may contact me for either or both of these by email: Katherine.ash@usask.ca.

Thank you for consideration of participating in this study. I look forward to discussing your experiences and understanding of your interprofessional experiences as a student volunteer in clinical practice.

Sincerely,

Katherine Ash RN Ph.D. Candidate
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